



The Pursuit of Quality: A Clinical Directorate's Progress in Clinical Governance

A Case Study of the Women and Children's Directorate, GUH (HSE)

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A Collaborative Research Project between GUH/W&Ch CD and UL.

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ABSTRACT

The aim of the overall study is to inform the design and delivery of a high reliability clinical directorate. This report is the result of the mapping phase in the case study of the Women's and Children's Directorate, Galway University Hospitals. It describes the current approach and the hospital's progress in providing a quality service. The policy context clarifies the external and internal influences affecting the present performance level of the Directorate.

The enquiry uses a mixed-method strategy to generate quantitative, qualitative, and documentary evidence. The findings provide perceptions of dimensions of clinical governance, and describe the nature and effects of context as opportunities and constraints on performance. Documentary evidence represents the intended or espoused state of performance, as well as realisation in structure, process and outcomes. Key findings from each method are triangulated on the basis of the emergent qualitative categories. While each method provides its own data set, the combined set of evidence is indicative of the hospital's theory in use as against its espoused theory.

This provides a foundation for the next step, i.e. the reflective phase of the project.

Foreword

The field of quality is a growing national imperative driving structural change, and presents a concomitant need for evidence. This study arose from the authors' interest in identifying the current status of quality management in Irish Acute Teaching Hospitals against a background of European wide research on quality in health care. The GUH quality and structural change initiatives provided an ideal opportunity to develop this theme. To date, the GUH achievements include ISOs in Obs-Gynae and HR, hospital accreditation under the Irish Health Services Accreditation Board's Acute Hospitals Accreditation Scheme (HIQA), UNICEF Baby-Friendly Hospital, Migrant-Friendly Award, O2 Ability Awards (HR), HSE National Achievement Awards and Excellence Through People Accreditation (HR).

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This project was resourced by the HSE through the Health Systems Research Centre, and the personal research time of Dr Peter Williams (by the Department of Manufacturing and Operations Engineering /Enterprise Research Centre, UL) and Dr Claire Armstrong (Research Scholar at Kemmy Business School, UL).

Format of the report

The contents address the general policy context, both external and internal, as influencer of current arrangements. A short literature review provides an overview of quality frameworks, mechanisms and external initiatives, health care management, clinical governance and clinical directorates that situate GUH experience. The research methodology uses a mixed method approach to capture the complexity of the environment. It includes survey instruments on clinical governance and the status of quality management, semi-structured interviews, focus groups, and document analysis. The findings are presented according to method employed. Key findings from the three methods are grouped for triangulation purposes on the basis of emergent categories from the qualitative analysis.

This maps the territory of intent and realisation and thereby provides a basis for a reflective phase with Hospital and CD management and staff.

1. Introduction and Background

The emergence and development of the CIM Project in the Irish context has been gradual. The associated focus on patient-centredness, clinical structures and evidence based practice will reframe quality management in acute care services in time. Meanwhile, at European level, the WHO-PATH and MARQuIS Projects aim to generate comparative knowledge on current QI strategies and effective practices in acute care hospitals.

A key axiom of the quality improvement movement is that organisational learning is a fundamental pre-requisite to performance management. A strong distinction is drawn in the literature on organisational learning between “espoused theory” and “theory in use” (Argyris and Schon, 1978). It is therefore to be expected that the exploration of consonance and dissonance between documentary evidence as representing espoused theory and elicitation of evidence of lived experience by interview and questionnaire, as representing theory in use, should prove productive in the pursuit of a path to improved quality of clinical service and outcomes in general.

The choice of GUH as a study site to elicit evidence of change for organisational learning and QI is due to its recent development of the Clinical Directorate structure. This is coupled with a hospital-wide accreditation process and CQI interest. Consultation with the Hospital Management and CQI Committee led to the choice of the W&C Directorate for the pilot study. This was followed by discussion and agreement with the Clinical Director and Team in that Directorate (Obs/Gyn & Paeds). The Directorate was established in 2006, and its Obs-Gynae Dept has well established ISO and CIS systems in place.

This project is a collaborative venture involving UL (Health Systems Research Centre, Enterprise Research Centre, and Kemmy Business School) and the GUH W&C CD team.

The high level aim of the study is to inform the design of a high reliability service unit of management to deliver safe and effective processes and outcomes. The overall project proposes a number of phases. This part of the study focuses on the

comprehensive mapping of the Directorate`s current approach and progress in the development of policy and practices that contribute to its performance in providing a quality service. Personnel in the Directorate were informed about the study by letter from the Clinical Director (dated 8th November 2007) and through meetings with the research team at Ward level and other contexts. The enquiry included three sources of data ie document review, survey and qualitative case study. This took place between Nov. 2007 and Feb 2008.

Preliminary findings were presented to GUH Management Team in July 2008 and subsequently two levels of report prepared. They identify the nature and effects of context on opportunities and constraints on performance in the CD as an essential input to reflection and learning from experience.

2. General Policy Context

The general policy context comprises external and internal elements.

2.1 External Policy Context

A number of national policies have influenced the GUH strategic, planning and operational statements. Those particularly in evidence are The National Health Strategy (2001) and the Health Services Reform Programme (2003), the HSE Corporate Plan (2005/08) and Transformation Programme (2007-10). National Goals 3 and 4 of the Transformation Programme (2007-10), which relate to 'responsive and appropriate care delivery' and 'high performance', respectively, are of particular importance.

Goal 3 sets out three objectives: the first is to place the patient at the centre of care delivery and provide a customer care programme & statutory complaints procedure, patients' management of own care / individual care planning, and participation by community in decisions through regional advisory panels/ consumer panels/ National strategy Forum. The second aims to provide appropriate care in an appropriate setting, referencing broader models of care, while the third objective is to provide timely and appropriate capacity. This points to a proposed plan to provide responsive high quality maternity care, and an undertaking to enhance the configuration, range and delivery of paediatric services. Goal 4 sets out two objectives. The first is for a standardised quality system to support best patient care and safety with an evidence-based approach at all levels. The second seeks that quality and continuous improvement would be embedded in daily practice. The achievement of these objectives requires considerable investment in information technology services, as well as a comprehensive, centrally driven integrated approach.

The HSE Corporate Plan (2005-08) and Reform Programme (2007-10) offer a coherent approach to the management and delivery of the service. Financial breakeven, value for money capacity, and information and communication technology (ICT) support and service modernisation. Actions focus on integration through care pathways and clinical networks, staff empowerment and teamwork, accountability with performance management and with planning levels, reports and performance monitoring framework, and external monitoring.

The Transformation Programme (2007-10) again prioritises an integrated service, comprising the National Hospitals Office (NHO) and Primary, Community and Continuing Care combined (PCCC), the management of chronic illness, standards-based performance management, and genuine staff engagement with the transformation programme. In the case of acute hospitals there is reference to evidence-based, efficiently-run, quality-assured services, their governance and management, the transformation of A&E, paediatrics and maternity care, performance measurement and integrative capability. Implementation of standards-based performance measurement requires an ethos of continuous improvement, development of a performance management system, integrated intelligence/analytical capability.

Clinicians in Management

The Clinicians in Management (CIM) initiative was launched in 1998 in 31 pilot-sites. Its objective was to give key professionals, namely doctors, nurses and allied health professionals, a greater role in the management, planning and development of health services. In order to do this, it prescribed two essentials. The first was a hospital management board that took key corporate decisions only with significant and real involvement by clinicians. The second was the devolution of authority and local accountability for the management and control of resources. Emphasis was placed on the devolution of responsibility, empowerment of the front line, a focus on patient needs and flexibility and openness to change. Many hospitals adopted a Clinical Directorate structure to facilitate this process. It is usually headed up by a Clinical Director (medical consultant), who is supported by a dedicated business manager, director of nursing and sometimes a director of allied health professionals

An Office for Health Management review (OHM, 2002) of the CIM initiative identified a number of issues which explained its limited success. For example, the purpose of involving clinicians directly in the management of hospitals was not well understood and there was a limited appreciation as to how it should be developed. Significantly, senior managers were unwilling to decentralise financial management until they were sure that clinicians would be appropriately responsible and corporate minded. It is also noted in the report that hospitals with prior experience of multidisciplinary team working were more successful in adopting the CIM approach.

As mentioned above, the National Health Strategy (2001) also envisaged the development of a seamless organisational structure that would integrate all services internally with the support of appropriately designed information systems. Greater interdisciplinary working amongst the professions was deemed necessary to extend the available skills range. The Strategy “renew(ed) emphasis on clinicians in management” and the expectation that staff at all levels would be empowered by devolving decision making responsibility to the lowest feasible level. It was noted, “for a partnership model to be effective, the old hierarchical thinking in relation to the professions must disappear along with the turf wars which are a barrier to patient care” (DOHC, 2001: 49).

In 2003, the OHM carried out an evaluation of the Mayo General Hospital Pilot CIM scheme. Their main findings emphasised four essential roles within any structure that provides for an effective CIM initiative: clinical director, nurse manager, quality projects officer and a CNM Forum. The roles of clinical director and medical director with executive powers emphasise CIM as a central concern of clinical governance in the construction of effective teams. Effective resource management relies on delegated financial control with budgets transferred from the General Manager to the Clinical Directorates. The expected results are: better patient outcomes, integrated and effective care by multi-disciplinary teams, satisfied patients, motivated staff, and devolved decision making supported by information systems.

Elements of the Health Service Reform Programme (2003) also signalled the devolution of responsibility for care budgets to the people actually in charge of delivering that care and the modernisation of support services such as planning and performance management. The latter would require an acceptance of personal accountability and responsibility for budgets by those that committed resources. Clearly clinicians were expected to be key players in this process.

Most recently, the Consultants Contract (HSE 2008) states that “the configuration of clinical directorates in the Irish context will provide for major intellectual debate and discussion given the range of various models currently in operation across many settings, especially those larger sites”. The configuring of CDs has been strongly favoured along the lines of the patient journey so that the range of clinical services addresses the needs of patients from point of entry to exit. The principal duties and responsibilities of the clinical director include: strategic input and clinical advice, leading the service planning process, monitoring and controlling

performance, and various matters affecting quality and staff management and user participation. Documentation accompanying the contract state that:

“Clinical Directorates will be responsible for how patient services ... are developed and delivered to defined populations across care groups, service settings, and professional disciplines. They must be large enough to justify comprehensive support by business managers thereby empowering them to drive change. This will require existing management resource, budgetary allocation, financial reporting systems, and other corporate and business functions to be adjusted. In practice this means that clinical directorates shall be based on a minimum of 30 – 60 whole-time consultant posts.”

2.2 Internal Policy Context

The documented evidence of Galway University Hospitals' intent and performance is primarily indicated in its hospital and quality management strategies and in the ISO and IHSAB Accreditation Reports. The Continuous Quality Improvement (CQI) strategy places quality at the centre of the organisational agenda. It states as follows:

“The vision for the strategy is about finding ways to ensure that clinicians and staff recognise and understand the need for continuous reflection upon the quality of care provided and learn from practice and mistakes to continually improve the services they are providing. Quality must be an integral part of Galway University Hospitals' business and in addition to activity and finance the quality aspect of service delivery must be always on the agenda at organisational meetings”.

The objectives of the quality management strategy are both multidisciplinary and participative, involving staff and patients. The key objectives are supported by a Quality & Safety Framework that connects CQI and Risk Management (RM) steering committees with the Executive Management Team (EMT). The principle CQI components are patient and public involvement, Clinical Audit (CA) and Integrated Care Pathways (ICPs). CQI strategy includes and is enabled by accreditation that aligns with the objectives of a quality improvement culture and environment, patient and staff safety, and an integrated delivery. In order to ensure a reliable system, some further changes are required: the extension of accreditation to clinical pathology, the development of integrated care pathways and patient records on both sites, hospital-wide performance indicators, participation in benchmarking programmes with external peers in a network monitoring framework, and the creation of an appreciative/rewarding environment. The priority CQI actions are the development of a baseline assessment, the identification of the key concerns of patients, the agreement of priorities and support for the emerging clinical directorates.

Risk management has two main components, namely general health & safety and clinical safety. The risk management programme prioritises the development of risk registers at both corporate and directorate level, the Patient Advocacy Programme and National Complaints Policy. Key concerns within risk management relate to the

categories of corporate risk entitled high risk and significant risk. These are addressed through the provision of assurance & specialist advice to the Hospital Executive Management Team (EMT) and Hospital Management Team (HMT), and specialist input to the risk management committee on a variety of safety topics e.g. health and safety, medicines and infection control.

Progress on risk management is demonstrated in the following: a Risk Management Strategy, the Risk Registers, STARSWEB, the development of a serious incident investigation mechanism during 2006, a risk management network in 2007, a protocol on clinical risk assessment and feedback mechanism. The goal is to minimise risk in providing a quality clinical service. A patient advocacy programme that manages complaints and the interface between patients and senior management complements this. At present there are *ad hoc* patient feedback mechanisms, but the goal is to involve patients routinely in service review and development. The training plan for 2006 references a comprehensive training programme on risk management for all levels and staff disciplines during the year.

The CQI Action Plan has delivered six clinical directorates since 2005 as part of its clinical governance framework. The CQI committee oversees the organisational quality improvement programme. Staff and users are involved via the directorates and accreditation QI Teams, service evaluation and focus groups.

Clinical Audit (CA) and Integrated Care Pathways (ICPs) are integral to the performance and management of clinical directorates. An annual programme expects each clinical directorate to identify 3 to 4 CA projects. It is expected to increase the proportion of multidisciplinary projects from 10% to 50%. The development of an integrated outcome measurement and audit for ICPs is planned. A record of CAs and ICPs is maintained in the directorate.

The external assessment of quality has progressed substantially in Irish hospitals during the course of the past decade. Since 1996, the maternity department in GUH has maintained its ISO accreditation successfully. The re-certification reports in 2006 and 2007 noted the department's commitment, continuous improvement and comprehensive quality system plan and management of quality. The institutionalisation of ISO has embedded the routine update of policy and practice reflecting current evidence and best practice. In order to encourage local ownership, there is general dissemination of proposed policy and practice updates to wards for

reference and review. This well documented approach provides a sound legacy and foundation for continuous improvement and accreditation.

The progress in GUH's hospital-wide accreditation since 2002 is noted in the 2008 report which conferred a Level Three Award on the hospital (ACAS/HIQA, 2008). Staff commitment to quality is evidenced by multidisciplinary team processes and professionalism. This achievement was realised by strong leadership and the development of Integrated Care Pathways (ICPs) across all main areas. The development of CDs was evidence of clinicians' willingness to accept corporate responsibility. Some improvements are recommended in relation to CA and outcomes measurement as well as environmental quality, and certain infrastructures and services. The report also refers to the need for clarity regarding staff roles, policy updates by the CQI committee, and a system of devolved budgets and responsibility to support the new directorates. The overall positive performance assessment acknowledges strong leadership, a QI culture, patient focus, risk management, integrated care, an interdisciplinary team approach and a population health focus.

The (Accreditation) Report on the W&C Directorate notes the strong, cohesive team support for the process with evident leadership from consultants, midwifery and nursing. Particular reference is made to the achievement of the Baby Friendly Hospital Award, the development of the Early Pregnancy Unit, a well developed research ethos, key PIs, the Annual Clinical Report, a comprehensive suite of guidelines and on-site documentation. There is evidence of continuous evaluation, ongoing education and training, health promotion, travellers' health, outreach antenatal education, and teenage parent support. Some recommendations include audit of patient involvement in ICPs, integrated multidisciplinary charts and follow up information from discharged patients, a system of outcome measurement and evaluation. Specific recommendations for improvement relate to the paediatric infrastructure and provision for older adolescents, and maternity outreach. These will likely influence future service performance and shape.

Overall, the report notes the excellent impact of the ISO, integrated care, an interdisciplinary approach, clinical leadership, patient-client focus and community links.

Clinicians in Management: GUH-experience to date

The GUH Clinicians in Management initiative is set out firmly as a central plank of the GUH Strategy 2006-2010. Several purposes are evident: concern for quality and risk, concern for integrating management and clinician leadership, concern for control and accountability (see figure 1 below).

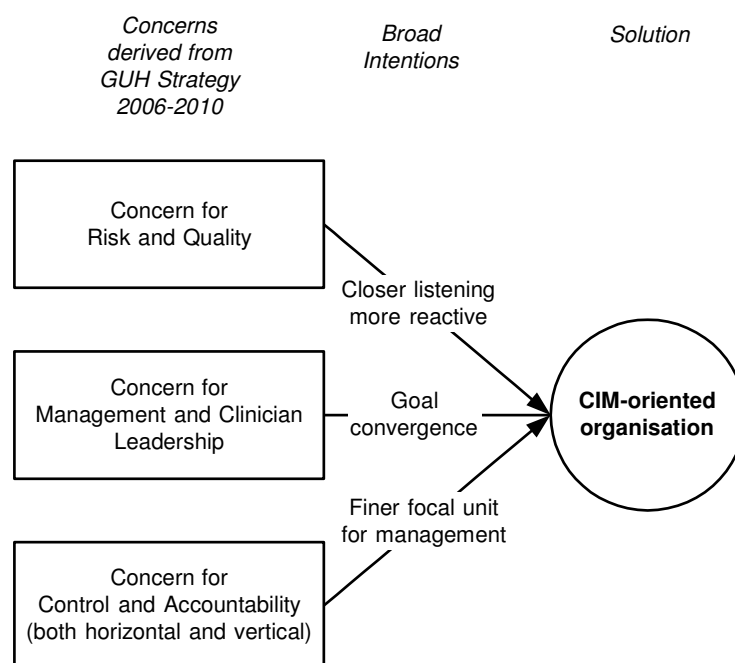


Figure 2-1. Impetus for CIM programme

The nature of the CIM model is implied throughout all hospital documents, in particular those relating to strategy and policy. Overall, the explicit presentation of CIM is set in a practical and concrete perspective (aimed at staff engagement). However, the documentation on the CIM model lacks details of origin and rationale.

Throughout the set of documents, CIM is equated with the Clinical Directorate structure, and the concept is fleshed out in a number of documents. CDs are described as “functional units with decision-making closer to the level of care delivery”. Stated advantages include: “better service for the patient”, “enhances the multi-disciplinary team”, “joint and more speedy decision-making at local level”, and “more appropriate

prioritisation between competing demands”. It is also acknowledged that “this will not solve all our problems but will help reduce ‘red tape’” (CD for Medicine in GUH, Nov 2006).

A five-step process to develop each directorate is outlined in “Flow-chart of Development Process of Directorate” (HR, GUH Dec 2007) as follows:

1. diagnostic interviews, and formation of steering group.
2. data collection via workshops, and site visits.
3. planning interventions with staff and management.
4. collation of outcomes as both model and structure.
5. compilation of report.

The CD has to maintain many lines of communication. The chart below (Figure 2-2) captures the most important reporting lines, drawing on job descriptions for Clinical Director and Business Manager, Terms of Reference for EMT, HMT and quality committees (CQI, RM, CA, ICPs etc), and GUH hospital and department organisation charts. It is noted that each management role has dual reporting lines with respect to the Director: The ADoN reports to the Clinical Director for operational issues and to the DN for professional issues; the AHP manager reports directly to the Deputy General Manager and secondarily to the Clinical Director (AHP WTEs do not appear on the formal CD WTE list); The Business Manager reports to the Deputy GM for administrative coordination and to the director for operational. The Deputy GM’s Dept includes the AHP managers, coordinators responsible for inpatients, waiting lists, discharges, and medicines safety, and also the posts of Medical Records Officer and Chief Pharmacists.

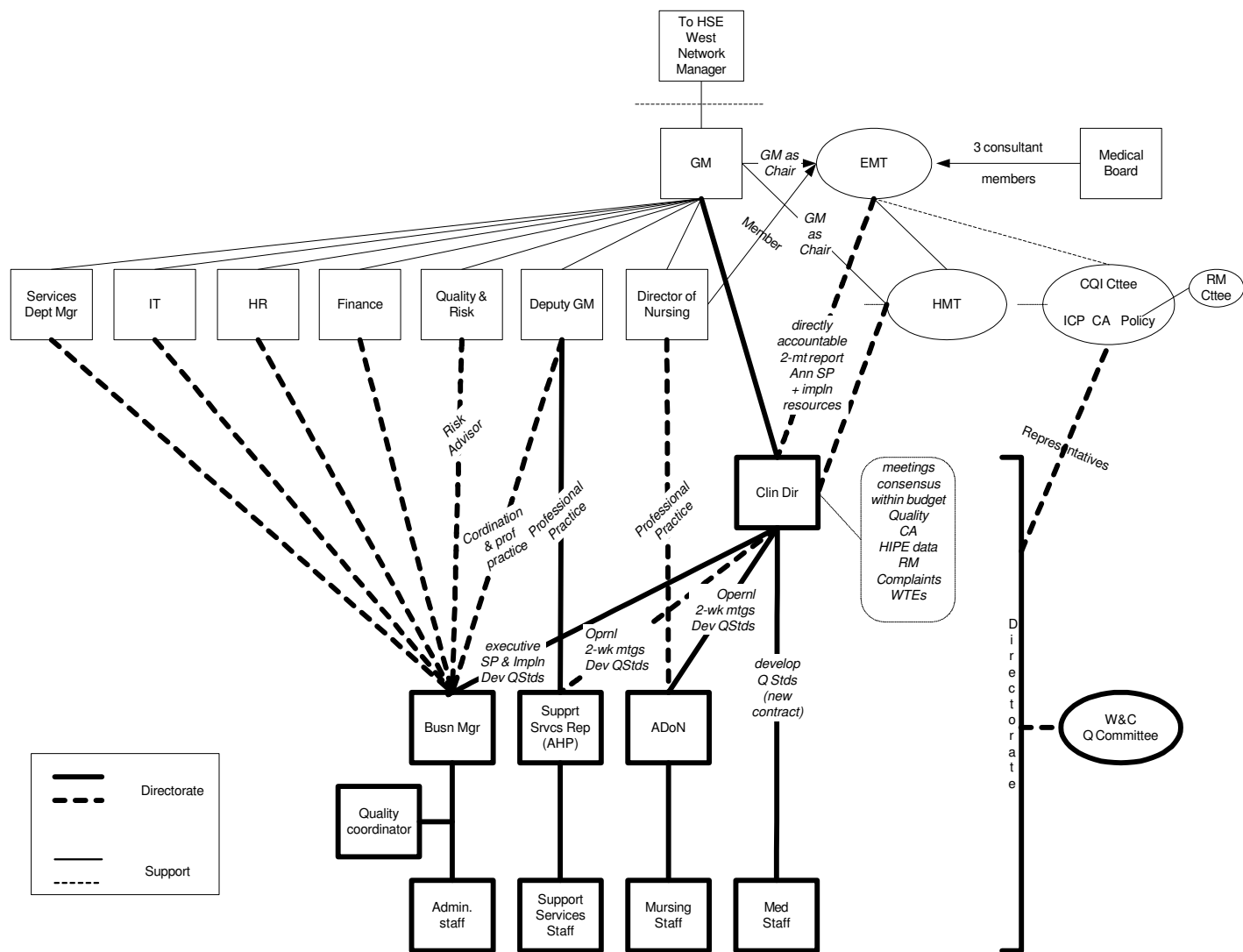


Figure 2-2. Location of CD in GUH Structure

A post-implementation staff review of the status of the W&C CD was carried out as a workshop in September 2007 (Clinical Directorate Workshop GUH Friday 14th September 2007). A wide range of staff were directly involved, and very open discussion took place. The thrust of the findings are that the Directorate is cohesive but expectations of control over finance in particular are unfulfilled. This constrains the Directorate's sense of identity and so further constrains it from fulfilling its purpose.

Key positive points indicate:

- goodwill for new system over old with less fear and suspicion,
- meetings regular and productive,
- a clearer focal point within which voices can be heard and better understanding developed between different professionals and departments, and between management and clinicians.

On the negative side, a sense of incompleteness is apparent:

- an open boundary (eg some decisions made outside CD structure);
- lack of autonomy re budget;
- incomplete allegiance/loyalty/buy-in to CD, need for more clarity in roles, and for more training/support; and generally a feeling of a rushed job.

Working groups established the need to counter a top-down tendency with a more bottom-up approach, embracing 'whole directorate', 'ground-up', and need for 'more pertinent' information for decision-making.

3. Literature Review:

3.1 Introduction.

The relevant extant literature includes quality frameworks and indicators, risk in healthcare, healthcare management, clinical governance, and clinical directorates. These references provide key concepts and themes for the reflective phase.

3.2 Quality Frameworks and Indicators

The growth in the quality movement has been accompanied by a large volume of literature, particularly in the commercial/private sector. It is important to understand quality frameworks and indicators from all sectors to appreciate the basis their application in the healthcare sector. In this report, most of the literature relates to healthcare, but many seminal references to key concepts are described in Appendix A.

The pursuit of superior patient experience and high organisational performance reflects more general difficulties of attempting to control dynamic, complex adaptive systems. Such systems involve people, complex inter-dependencies, high risk, waste, and costs. Healthcare is substantially different to commercial production as it entails change in personal health status, variable presentations, and dependence on the role of the professional providers in making appropriate diagnoses and choices.

The 1990s saw a growing appreciation for the need to address a real deficit, as represented in the milestone Institute of Medicine (US) report ‘To Err Is Human’ (1999). This focused public attention on the massive number of ‘avoidable’ deaths in healthcare, estimated to be in the range 45,000-90,000 per year in US hospitals, and was instrumental in raising awareness of the need for structured approaches to quality management, both nationally (US) and internationally. This pointed to unnecessary variation in clinical outcomes, and the need for evidence based delivery.

While Total Quality Management (TQM) has been widely attributed with positive outcomes in manufacturing and services industries in general, its application in healthcare has had mixed reports. For example in the UK NHS, Joss and Kogan (1995) discuss the failure of TQM. In contrast, TQM is widely adopted in healthcare in the USA – for example by the VA organisation, making major and sustained performance advances in the 1990s. The development of TQM-inspired group problem-solving activity is seen in ‘Breakthrough Collaboratives’ (Ferlie and Shortell,

2001; Ayers et al, 2005). Conditions of trust, an integrated philosophy of quality improvement, a focus on process and outcome measurement are keys to successful change (Ayers et al., 2005).

3.2.1 External Frameworks

Institutionalised programmes such as ISO 9000 evolved QA to a larger international canvas. The European EFQM model (fig. A1)?? was developed to incorporate CQI-focus in a multi-dimensional, hierarchical framework for any large organisation (EFQM, 1999; Wadsworth et al, 2002): The two blocks present at the highest level, Enablers and Results, are expanded to form the dimensions Leadership, People, Strategy & Policy, Partnerships & Resources, Processes, Results for People, Customer, and Society levels, and Key Performance Results. In 2000, the ISO 9000 series was updated to strongly incorporate Continuous Improvement (9001 at unit level, and 9004 at organisation level).

3.2.2 EU Healthcare Initiatives.

The EXPeRT project identified four models of external quality mechanism in Europe: Visitation; Accreditation; EFQM; and ISO (Shaw, 2000). EFQM has been widely used in hospitals in Europe (Nabitz et al 2000). The milestone WHO-PATH framework (fig A3) was developed to capture a wide range of stakeholder values for internal quality improvement based on self-assessment and peer benchmarking. The framework consists of four vertical dimensions (clinical effectiveness, efficiency, staff orientation, responsive governance) and two transversal dimensions (patient safety and patient-centredness). A PATH-EFQM model has been proposed to embed CQI with multiple-dimensional performance. The MARQuIS project (2007) is currently examining the state of continuous improvement and organisational learning across a wide range of hospitals in the EU states.

3.2.3 Quality Indicators

Performance indicators form the heart of any quality framework. They act as barometers, and should discriminate between desirable and undesirable practice. Donabedian's 'Structure-Process-Outcome' construct is widely used to frame discussions around quality management in health systems. Structure refers to relatively stable features (e.g. facilities, organisation), process to lived experience of work and how things are done in practice, and outcomes refers to change in health

status (Donabedian, 1968/1981). Donabedian stresses the necessity to concentrate on assessing both process and outcome indicators for improvement activities. In any quality system, it is important for distinction to be drawn between results which are meaningful to patients/customers and process measures which are meaningful to management. The provision of quality indicators/measurement has proven very difficult for healthcare (CEMACH 2007): it requires routine data availability, and IS/HR capability on data quality and data analysis. Low numbers of failures are a challenge, and make detection of underlying systematic problems difficult. Because of this, indicator design and selection for health services remains a hot research topic. A selection of current healthcare indicator sets from the literature are presented in table A1.

Mainz (2003) identifies seven key attributes of an ideal indicator for health systems:

- agreed definitions,
- specific and sensitive,
- valid and reliable,
- discriminates well,
- relates to clearly-identifiable events for the user,
- permits useful comparisons,
- evidence-based.

The Agency for Healthcare Research and Quality (AHRQ; US) has developed indicators with three objectives in mind: to support quality improvements at hospital and at area levels; to inform patients; to support purchasing. Criteria considered in their development were:

- face validity (clinical rationale, likelihood of distinguishing between the quality of care between providers/areas),
- precision (of variation that is not random),
- minimum bias (little effect on indicator of variations in for example patient disease severity or socio-economic status),
- construct validity (compares well with other measures to measure same underlying question),
- fosters true quality improvement,
- prior uses (effectively used before in practice).

The PATH framework is elaborated to 22 core and 17 tailored indicators, presented in dashboard format for peer-comparison. The indicators are system-specific, not specialty-specific – thus are ‘barometers’ for full-service unit.

3.3 Risk in Health Care

The field of risk management has its roots in hazard analysis and loss prevention in the process and transportation (especially aviation) industries. Lees (1995) is instructive in this regard. This knowledge domain is gradually being adapted in the challenge of patient safety and the creation of high reliability in healthcare organisations (Clancy and Reinertsen, 2006).

3.4 Healthcare Management

Public Healthcare Management is best understood within the context of the historical and contextual influences of Public Administration and the emergence of New Public Management (NPM) in recent decades. The traditional model of public administration is rigid and hierarchical and follows from a basis in rules, impersonality and neutrality. The Fulton Committee Report (UK) of 1968, prompted by concerns about the power of the civil service, recommended the principle of accountable management, the reduction of hierarchical levels and integrated units of management. The Strategic Management Initiative (Irl) 1994 was extended to the whole public service in 1997 in response to public perceptions of poor performance and the need for value for money. Clarification of the allocation of authority, accountability and responsibility in the system was exemplified in the Health (Amendment) (No.3) Act, 1996. Its objectives were to strengthen and improve arrangements in relation to financial accountability, to clarify roles of Health Board members and CEOs and to begin a process to remove the Dept of Health and Children (DoHC) from detailed involvement in operational matters. All changed with the abolition of the Boards and the delineation of new boundaries of responsibility between the DoHC and the new unified healthcare system, ie the Health Services Executive, from 2005 (Prospectus Report, 2003; Health Act, 2004). Unlike the Prospectus Report, the Brennan Report retained the regional health boards. Recent developments suggest a return to a form of integrated regional administration under the HSE. Will they reflect Ferlie et al’s (1996) necessary elements of NPM ie ‘downsize and decentralise’ with a strong

emphasis on culture and leadership, shared vision and values and a public service orientation in applying private sector management techniques?

Flynn & Strehl's (1996) comparative European study observed many identical features of NPM. They included improved accountability, more autonomous decentralised service, performance measures and targets, cost reduction and competition. The HSE initiative needs to be assessed against such criteria and in the current context of comparative EU public health care systems. In addition, there are the three elements of the WHO policy of 'Health for All' that were reflected in the two Irish National Health Strategies (DOHC 1994, 2001) ie lifestyles, prevalent conditions and population health gain. These are matters that concern serious inequalities in health between groups and regions.

There are several confounding issues in reforming healthcare systems. Technically, health care reform is complex. It needs a sound infrastructure with good information systems, management skills and resources to put new organisational arrangements in place, and collaboration (Saltman & Figueras, 1997). Health care systems have an unusual dynamic created by the interaction of five different worlds – scientific, professional, political, public and industrial (Dawson, 1999). In particular, Domains Theory (Kouse & Mico, 1979) highlights the differences between competing groups - policy, management and service. The policy domain responds to the needs and demands of the electorate; the management domain develops ways of meeting accountability issues and the professional providers develop best services for clients while affiliating to a professional culture rather than any specific organisation. Each domain approaches the issue of service integration differently. Separate identities prevent the development of a common vision that leads to the destruction of any sense of coherence and connectedness (Edmondstone, 1986). The bureaucratic and collegial organisations co-existing within the same social framework present a paradox of control and autonomy.

There are consequential dilemmas in clarifying the nature of leadership and the design and implementation of change processes in such contexts (de Burca, 2003). In the U.K., the impact of successive institutional reforms and philosophies in the NHS on the professions were assessed in Walby and Greenwell (1994) and Harrison et al., (1992). This is reflected in the evolution of a hybrid culture that is the fusion of professional and managerial systems and ideologies rather than merely roles. The challenge is described further in relation to Clinical Governance and Directorates.

3.5 Clinical Governance

A popular definition states that clinical governance is “a framework through which National Health Service organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish” (Scully & Donaldson, 1998: 61). The UK Department of Health (1999) outlined the three main principles of clinical governance as follows:

- Clear lines of responsibility and accountability for the overall quality of clinical care,
- A comprehensive programme of quality improvement systems e.g. clinical audit, evidence based practice, clinical standards/guidelines, workforce planning and development and staff education and training,
- The identification and remedying of poor professional practice.

The adoption of governance by the health care system had two main sources. One arose from the waves that occurred through the New Public Management (NPM) movement taking on board the crises of critical failures in the private and public sectors (Hood, 1991). That emphasised closer links between corporate and clinical governance in health care organisations. The other emanated from the WHO in 1983, which proposed four interrelated dimensions of governance in clinical settings i.e. professional performance, resource allocation, risk management and patient satisfaction (Penny, 2000). The adoption of the concept in the UK NHS was particularly evident at the turn of the last century. Though the term ‘clinical governance’ is not, as yet, in the Irish health care system’s vernacular to any great extent, it does underlie what GUH expects to achieve by the use of CDs.

Initial Irish reviews of QI demonstrate that it is at a development stage (Ennis & Harrington, 1999). Its quality assurance and clinical audit history is not dissimilar to that reported internationally. Accreditation, does, however, appear to be the main instrument of change in acute hospital care at present. This is administered by HIQA (formerly known as IHSAB) in an adaptation of the Canadian model. It has limitations because quality and safety are multidimensional, current measurement is immature, clinical indicators are not mandatory and the structure and processes are

not necessarily linked sufficiently closely to outcomes. Accreditation should be complementary to other QI tools, rather than a means to quality improvement in itself. Recent HIQA reports on quality in Irish acute hospitals present a challenge to management and the ratings reported by irishhealth.com are a recurring cause of consternation for some. In contrast, the ISQSH patient satisfaction ratings present well overall. This is accompanied by some favourable reports on clinicians in management (OHM, 2003) although the empirical evidence is limited.

Clinical governance failures are not unlike TQM/CQI failures (Joss & Kogan, 1995) in that they may result from poor leadership and an inappropriate organisational climate for change. Consultants' attitudes towards clinical governance are central to its success or failure. Hogan et al's (2007) study of two large acute hospitals reports findings that relate to high and low consultant involvement in QI initiatives. Although both hospitals were subject to the common impediments of an overall lack of time and the availability of accessible data, high consultant involvement was associated with effective communication. This enabled good continuous quality improvement with all staff groups, clear structures and processes to support clinical governance and senior management that understands the issues.

A major cross-sectional study of progress in clinical governance in the UK (Freeman & Walsh, 2004) identified 54 competency items and aggregated them into five broad domains, namely improving quality, managing risks, improving staff performance, corporate accountability, and leadership and collaboration. The most important perceived achievements were in corporate accountability structures and clinical risk. The highest shortfalls occurred in joint working across local health communities, feedback on performance data, user involvement across QI, leadership and collaboration. Interestingly, neither the type of Trust nor the stage of implementation of the clinical governance initiative had any impact on perceptions of progress.

3.6 Clinical Directorates

The Clinical Directorate model originated in the US (John Hopkins` Memorial Hospital, 1973) and was influenced by the need to engage clinicians in management for effective performance and resource management. In return for freedom to manage their own affairs, doctors had to accept responsibility for financial resources. The hospital was organised as a holding company for a series of 'specialty hospitals'

(clinical directorates). By 1983, the model had been adopted to the extent that 80% of clinical directors had financial control, and the directorates operated with a lower cost growth rate than traditional models. Traditional hospital arrangements maintained the medical collegiate power lines while the non-medical professions accountability flowed to the General Manager. This created tensions between medical autonomy and managerial authority and resulted in barriers to service integration (Harrison & Pollitt, 1994). The UK Resource Management Initiative pilot programmes introduced in 1986 were expanded to the entire NHS in 1989. It gave clinicians responsibility for budgets and thereby integrated clinician involvement into hospital decision-making. Many adopted the Clinical Directorate model, although Packwood et al (1991) reported implementation difficulties including costly implementation, and inconclusive evidence of patient care benefits.

While the intention is to make the service more streamlined, patient centred, multi-disciplinary and cost effective, the noteworthy empirical studies indicate that the CD model has only slight evidence of better efficiency than the traditional model (Braithwaite, 2006, 2007; Braithwaite et al., 2005). An attitude survey of professional staff in CDs in two large hospitals reported significant differences across disciplines. Doctors were most negative towards the CD, AHPs most positive with nursing more polarised. 58% of respondents reported that the CD affected organisational policies, 48% reported improved accountability, and 26% reported improved patient care (Braithwaite, 2005). A further study by Braithwaite et al., that year cited the most frequent criticisms as inefficient organisation of change, poor management, lack of staff cooperation, and failure to empower health practitioners, power redistributions causing opposition to new clinical structures, more intense conflicts between managers and clinicians, curtailments of hard-won clinical autonomy, and compromised professional values.

Earlier work in the UK had suggested that clinical directors had limited understanding of the concepts of leadership and motivation, and that they were uncomfortable in the role of influencing peers. These were attributed to interpersonal aspects and a lack of training (Willcocks, 1994). In the latter study CDs were reported as being loosely defined and therefore, allowed to evolve with role ambiguity. These problems persist. For example, the Royal College of Obstetricians and Gynaecologists (2005) prioritises deficits in clinical management roles for urgent attention, especially in the context of legal claims (ref. Clinical Negligence Claim Scheme for Trusts):

“The training for these (clinical management) roles is generally poor, and in many cases the duties are often passed in line from one consultant to the next without due preparation. Effective planning in training and preparation must become the norm. There should be clearly identified leads for: delivery suite, clinical governance and risk management, audit, guidelines.”

The Clinical Directorate (CD) can be described as an aggregation of common or complementary clinical services comprising related wards, units and/or departments (Braithwaite et al, 2005), the aim of which is to streamline the patient experience, reduce clinical risk, improve patient outcomes (Lathrop et al., 1991) and reduce costs (Packwood, Keen and Buxton, 1991). Castelli & Morandi (2007) claim that Directorates are the best context in which clinical governance can be delivered. Their study of the diffusion of directorates in Italy noted five different meta-solutions to group ward units within clinical directorates, as follows:

- Nosological
- Specialistic
- Organ or Apparatus
- Intensity of Care
- Age Class.

This is one of the few studies to categorise grouping of service departments in directorates.

4. Research Methodology ¹

4.1 Research strategy: multi-method approach

To explore the nature of quality management in the context of a Clinical Directorate or hospital it is essential to recognise the variety of perspectives and responses that may occur at multiple levels, and within different disciplines and settings. Thus a multi-method strategy is required. Multi-method strategies accept that all research approaches may be used in the same study, provided the contribution of each approach can be identified (Denzin, 1970, Campbell & Fiske, 1959). The present study adopts a sequential design that commences with survey instruments to assess the evidence of objective data. This is followed by a more dominant influence from qualitative data generated by a multilevel approach and document analysis. Thus quantitative data is incorporated into qualitative research.

4.2 Research Methodology

Though every method has its limitations (Campbell & Fiske, 1959), the use of triangulation and pragmatism with qualitative and quantitative methods, depending on the research question and the phase of the research cycle, minimises the effect of such limitations. Pragmatics use both inductive and deductive logic (Tashakkori & Teddlie, 1998), thus providing both objective and subjective points of view. They recognise the role of values and accept external reality.

Survey instruments

Self-report is well nigh ubiquitous as a form of data collection in organisational behaviour and management research. There are no direct means of cross-validating peoples' descriptions of their feelings or intentions (Podsakoff and Organ, 1986). Survey research focuses upon causable explanations derived from correlations but which cannot deal with the social meanings thus described (Finch, 1986). The causal model fits with the natural sciences, but the fundamental difference with the social world is the subjective quality of human action which has an internal logic of its own (Laing, 1967: 53). In qualitative research the focus is on meaning whereas in

¹ Project aim and methodology cleared with the Chairman of the UL Ethics Committee on Thursday 3rd August 2007.

quantitative research the researcher attempts to measure variables. A reliance on self-reports limits the opportunity for discovery of ambiguities, of tasks and of social relations (Hamlin, 2002). Qualitative approaches involve observation, in-depth interviews and the detailed examination of documents, and are acutely sensitive to context and processes (Bryman, 1997).

Interviewing

Interviewing is most valuable when the person engaged in the fieldwork comprehends the fundamentals of a community from the insider's perspective, as the questions are more likely to conform to the native's perception of reality. Open and closed questions help discover and confirm the participant's experience and perception. Tape recording is used judiciously and with consent and facilitates transcribing that is necessary for analysis (Hammersley & Atkinson, 1983).

Focus Groups

Focus group research involves a moderated group discussion and may produce a rich body of data in the respondents' own words and context. Stewart & Shamdasani (1990) refer to a variety of research needs which lend themselves to the use of focus groups: obtaining general information about a topic of interest; learning how respondents talk about a phenomenon of interest and generating research hypotheses. They are a useful vehicle for facilitating a common understanding of issues and problems. Limitations arise in respondent interaction or bias introduced by a dominant member.

Data Analysis

SPSS software was used to analyse the Clinical Governance Survey and the Clinical Governance Climate Questionnaire (Field, 2005).

Template Analysis

Template Analysis (King, 1998) was used to thematically analyse the qualitative data from interview transcripts. It involved the development of a coding template, which summarised themes in the data set and organised them in a meaningful manner. Hierarchical coding was emphasised; in other words, broad themes encompassed successively narrower, more specific ones. The analysis started with some *a priori* codes, which identify themes strongly expected to be relevant to the analysis. An initial template was developed after initial coding. This was applied to the entire data set and modified in the light of careful consideration of each transcript.

Document Analysis

Documentation provides evidence of espoused theory and of theory in use (Argyris and Schon, 1978). This translates into “intent” and “realisation”. Intent comprises policy, strategy, planning and evaluation. Realisation is characterised by Donabedian’s classical triad i.e. structure, process and outcome (Donabedian 1968, 1981).

4.3 Quantitative Research procedure:

The quantitative study combines:

1. A summary of the status of quality management in GUH through the MARQuIS instrument as used in the international study (www.MARQuIS.be).
2. A brief Quality Audit statement for the W&C Directorate
3. The Clinical Governance Survey (CGS), which identifies awareness of quality roles and activities
4. The Clinical Governance Climate Questionnaire (CGCQ), which assesses the prevailing clinical governance climate within the organisation.

4.3.1 MARQuIS

The MARQuIS survey instrument was developed under the EU FP6 project Method for Assessing Response of Quality Improvement Systems (MARQuIS). The instrument is formatted with components that describe the hospital strategy, structure, planning, and QI policy/strategy/structure/processes/outcomes. It assesses the degree of use and implementation of QI systems and activities, including formal external accreditation or quality award systems. It assesses the linkage between leadership and implementation. The range and extent of implementation activities and patient involvement is reported. The instrument was completed by GUH for inclusion in the overall European analysis. In total, 28 Irish hospitals took part in this exercise.

4.3.2 Quality Audit Template (Lugon & Secker-Walker, 1999)

Quality cost is an important driver for top management commitment (eg Feigenbaum, 1993: Chap 6). To justify the cost of control, the cost of failure of control must be mapped. Lugon & Secker-Walker provided a useful template to pose to CD management appropriate questions in a hospital and specialty context. (see copy of Q Reporting Template in appendix B).

4.3.3 CGS and CGCQ Surveys

The sample for the survey aspect of this study consisted of 110 health professionals working in a single CD, in a publicly funded, Irish academic teaching hospital. Three years before this study commenced, two departments within the hospital had combined, to form a single Clinical Directorate. The total population of personnel on the CD staff roll was 390, including staff working or assigned less than full time to the Directorate.

The survey instruments and cover letter from the clinical director were distributed to staff in the CD through internal mail. A number of visits were made throughout the CD, including presenting to a Clinical Review Meeting by the researchers, to explain the nature of the study and encourage participation. These surveys were, as described above, the Clinical Governance Climate Questionnaire – CGCQ (Freeman, 1999) and the Clinical Governance Survey – CGS (Lugon & Secker-Walker, 1999). The CGS was primarily used as an awareness raising exercise to orient participants towards the concepts of clinical governance and quality improvement. The CGCQ aimed to examine the respondent's perceptions of different aspects of clinical governance within their CD.

Following preliminary analysis of the results from these two questionnaires, interviews and focus groups were carried out. This was to allow the researchers to gain a more in-depth understanding of how key individual staff members believed the CD was operating, and of the facilitating and constraining factors present within the health service and that influenced the success or otherwise of the CD.

4.3.3.1 Response Rates

The total population of staff in the CD was 390, yielding an overall response rate of 27.9%. (Table 4-1). Of the respective populations the responses were:

Levels: combined* managerial and supervisory 72.5%, and 21.2% non-supervisory.

Role Categories: medical 37.5%, nursing/midwifery 25.2%, AHP 50.0%, administration/management 45.5%, and 'other' 23.1%.

Note, cells with counts of 5 or less are not presented for L1/2 and L3 in the table below.

Category	Level	L1/L2 Supervisory	L3 Non-supervisory	Total
Medical		40.0%	36.7%	37.5%
Nursing/Midwifery		69.2%	18.4%	25.2%
AHP				50.0%
Admin/Mgt				45.5%
Other				23.1%
Total		72.5%	21.2%	27.9%

Table 4-1 Response rates for survey questionnaires

Experts suggest that a response rate in excess of 70% is desirable. However, a difference may be expected between levels of responsibility. It is also suggested that respondents will participate in a survey if the anticipated rewards of doing so are equal to the costs of responding (McColl et al., 2001).

4.3.3.2 Clinical Governance Survey – CGS (Lugon & Secker-Walker, 1999)

The prime purpose of this questionnaire was to raise awareness and engage respondents, but some valuable information was gleaned and is reported later. It consists of 14 questions, comprising a total of 30 items. These items can be conceptually grouped into three main categories, firstly presence of key clinical governance infrastructure (including personnel), actions associated with good clinical governance and finally overall perception of the quality of clinical governance in the clinical directorate.

4.3.3.3 Clinical Governance Climate Questionnaire – CGCQ (Freeman, 2003)

Consistent with quality theory and practice as outlined earlier, it is assumed in this project that organisational culture and climate provides the ecology within which clinical service reliability and organisational performance outcomes in general may develop. This questionnaire was developed specifically to examine the link between organisational culture, climate and performance in clinical governance (Freeman, 2003). It has consistently attained high internal consistency and external validity in a study population of NHS Healthcare Trust staff. It consists of 60 items distributed across six sub-scales of clinical governance: planned and integrated quality improvement, pro-active risk management, absence of unjust blame and punishment,

positive working relationships with colleagues, training and development opportunities and organizational learning.

4.4 Document analysis procedure:

4.4.1. Document Collection

Requests for documentation relevant to quality management in the Women's and Children's Clinical Directorate were channelled through the Business Manager and HR department. The Obs/Gynae quality coordinator explained the ISO quality manual, the associated central master filing system, guidelines and protocols and so forth, located at the directorate wards. HR staff provided copies of numerous documents relating to staffing, training and performance. The IT Manager provided information on systems in place and the current IT work plan, locating it with respect to national developments. The Risk Manager provided significant documents, including a copy of the Incidents Report Summary for the CD, and the MARQuIS survey (hospital level).

4.4.2. Document Analysis

The documents were arranged according to intent (espoused) and realisation. Intent includes policy context, strategy, planning, and evaluation. Realisation includes structure, process, and outcomes (not evaluated), following Donabedian (1968, 1981). These headings are elaborated as follows:

Policy Context. These constitute the external documents that directly informed strategy, planning and so forth, i.e. from outside GUH - for example 'Quality and Fairness' (DOHC, 2001).

Strategy. These form the highest level thinking, internal to the organisation, including vision and mission, and the more detailed long-term aims of the hospital, for example, the 'GUH Strategy for the Future 2006-2010', or 'Risk Management Strategy and Policy'.

Planning. Planning in a health services context relates to annual rounds of plans which result in investment projects – large or small – committing resources to improve or extend/reduce service delivery capacity and capability, for example the CD contribution to the GUH Service Plan for submission to the HSE central administration for consideration, or the IT work plan.

Evaluation. This refers to interpretation of performance with regard to intent.

Structure. Refers to relatively stable elements within which healthcare processes are carried out, for example physical infrastructure, staffing, organisation structure, permanent committees, schedules, design procedures (e.g. for ICPs).

Process. Refers to the operationalisation of policy and planning on a day-to-day basis. Includes instances of procedures such as guidelines, Integrated Care Pathways (ICPs), and so forth. The Quality Manual has been located at this level in as much as it is a record that reflects formally how things actually work on the ground.

Outcomes. This includes information and data that represent the result of process, focused on change in health status, for example clinical outcomes and volumes of patients treated, risk-related incidents, costs.

These were further categorised according to hospital and stakeholder levels to differentiate formal policy-formulated perspectives (ref Jaques, 1978).

4.5 Qualitative Research procedure:

Qualitative data collection was undertaken with semi-structured interviews at manager/supervisor levels, and focus groups with frontline ward staff.

4.5.1 (a) Semi-structured interviews

These interviews were undertaken at three organisational levels i.e. hospital (n=8), clinical directorate (n=4) and department (n=6) based on role relevance and availability. The time range of the interviews was from 30 minutes to one hour. The interviewer/facilitator used a five-question schedule and prompts (appendix B0) to elicit responses relevant to the topic while his research colleague digitally recorded the interview and simultaneously recorded clarificatory observations.

4.5.2 (b) Focus Groups

Two mixed discipline groups of frontline staff were invited to participate in focus group discussions, each one hour in duration. The O/G and Paediatrics departments provided five staff members representing midwifery, HCA and administration. The discussion was facilitated by the same interviewer/facilitator as previously, using the same question schedule as above, while the research colleague digitally recorded the prompts and responses and noted inputs and non-verbal factors.

4.5.3 Qualitative Analysis

Each interview and focus group session was recorded and transcribed in strict confidence. Texts were formatted in accordance with question and response, and coded line by line. This generated working categories, sub-categories and properties. A grounded template for comprehensive data analysis emerged for comparison across texts. This was tested by comparing themes/categories within and across data groups. The outcome was the Template A Report and its Basic Framework and Origins.

The Template A report (Appendix D) was re-analysed thematically to produce a second analytic report (Template B, Appendix D). This provides the summary qualitative findings (see later). Both templates A and B (Appendix D) have a common database and constitute auditable documents with data fragments traceable to levels, departments and disciplines (ie Origins).

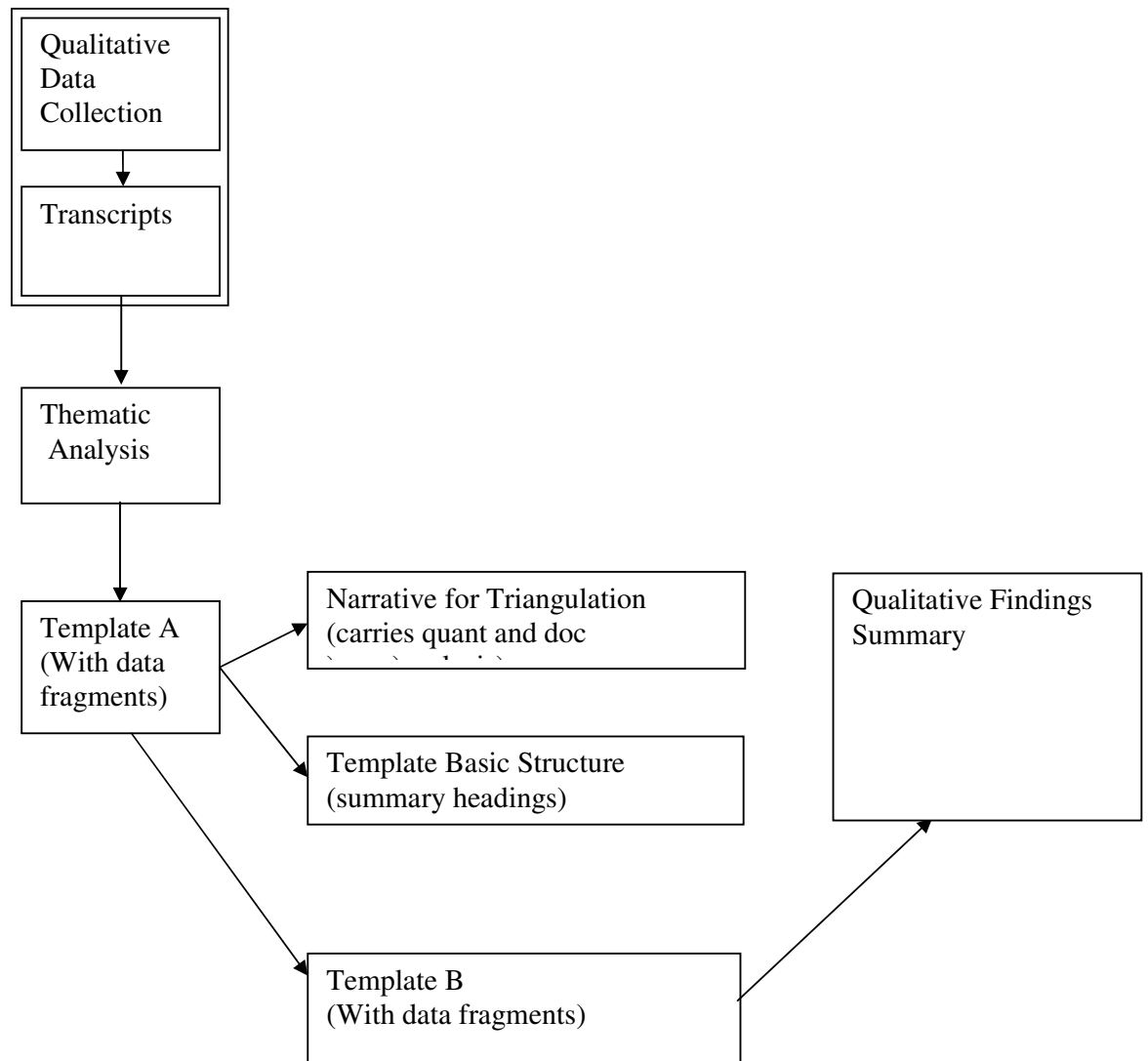


Figure 4-1. Development of Qualitative Findings

5. Findings

The findings are presented on the basis of the different methods employed to generate data. They are presented in the following sequence: quantitative, qualitative, and documentation. This is followed by a triangulation scheme formatted on the basis of emergent categories in the qualitative data analysis (Template A).

5.1 Quantitative Data

Results are presented for the following survey instruments: MARQUIS, Audit template, CGQ, CGCQ. Also presented are: resonances between CGQ and CGCQ factors; dominant issues arising in responses to factor items.

5.1.1 MARQUIS

The survey results for GUH provide context e.g. the hospital structure and number of employees. The top three QI priorities are: external assessment, patient safety and clinical practice guidelines. The influence of ISO and IHSAB is emphasised. Many important QI items are monitored at top level e.g. clinical indicators, complaints, incident reporting, audit, activity data etc. Regarding internal QI activities, most departments systematically review adverse events and patient views. However, obtaining the views of referring professionals is not undertaken systematically. In the case of staff performance, there are no regular reviews. There is little systematic involvement of patients. There are specific individuals identified for QI in respect of: hospital infection, patient safety, blood transfusion, antibiotics, decubitus (bed sores), and health promotion. See Appendix B2 for summary of MARQuIS/GUH.

5.1.2 Quality Audit Template

There are no data on costs attributable to the Directorate. However, there is a detailed summary of incidents for the directorate (31st October 2007 to 29th Feb 2008). It shows distribution of incident types in 16 classes and the number under each class occurring at the different standard severity rating levels. Sorting the data profile provided in descending order of importance (combining scores at moderate and high

risk levels) shows the most frequent classes of incident. These range from Treatment Incident (70) to Discharge Incident (1).

Table 5-1. Incidents and Risks – Women’s & Children’s Directorate (31/Oct/2007 – 29/Feb 2008)

Incident Type	Risk Rating						Serious	Total
	Very Low	Low	Moderate	High	(Moderate + High combined)	Unrated		
Treatment incident	4	12	38	32	70	16	0	102
Other	2	6	26	14	60	12	0	60
Peri-natal	7	40	38	10	48	22	0	117
Records/Documentation Incident	1	2	15	5	20	3	0	26
Slips/Trips/Falls	6	18	10	1	11	5	0	40
Not specified	6	9	9		9	9	0	33
Equipment/Device Incident	0	2	5	3	8	2	0	12
Medication	1	2	4	2	6	11	0	20
Diagnosis	1	2	4	2	6	2	0	11
Infection control incident	1	1	4	2	6	2	0	10
Unplanned events	0	1	6	0	6	2	0	9
Peri-operative/- procedure incident	0	3	4	1	5	0	0	8
Violence/Harrassment/ Aggression	1	1	3		3	3	0	8
Absconsion	0	0	1	2	3		0	3
Blood transfusion incident	1	1	2	0	2	0	0	4
Discharge incident	0	0	1	0	1	0	0	1
Consent / confidentiality incidents	0	1	0	0	0	1	0	2
Total	31	101	170	74		90	0	466

5.1.3 Clinical Governance Survey CGS

Due to the nature of this questionnaire, statistical factor analysis was not possible. However, items in the questionnaire can be conceptually grouped into three main categories, ie presence of key clinical governance infrastructure (including personnel), actions associated with good clinical governance and finally overall perception of the quality of clinical governance in the clinical directorate.

Key clinical governance infrastructure:

Within the ten items that refer to the existence of key clinical governance infrastructure, six items relate to the existence of individuals specifically charged with responsibility for processes related to quality and risk. The question was phrased ‘Does the service have an individual responsible for management of the following areas?’ Areas mentioned included clinical audit and setting service quality standards. Other questions related to other types of infrastructure such as the existence of a clinical audit programme and hospital incident reporting mechanism. The responses to these questions were binary (yes/no) in form, though some answered ‘don’t know’; therefore, it is included as a response category in the table

Table 5-2 Response and frequency relating to key CG infrastructure

Item	n	Yes (%)	No (%)	Don't know
Individual responsible for clinical risk management? (Q4a)	105	88	12	0
Individual responsible for setting service quality standards? (Q4f)	97	87	13	0
Individual responsible for clinical audit? (Q4b)	105	86	14	0
Individual responsible for complaints? (Q4c)	101	84	13	3
Existence of clinical audit programme? (Q9)	101	82	17	1
Individual responsible for workforce planning? (Q4d)	98	72	25	3
Individual responsible for coordination of clinical effectiveness information? (Q4e)	97	71	27	2
Does the CA programme involve all relevant clinical staff? (Q10)	88	69	24	7
Quality meeting multidisciplinary? (Q14)	81	67	31	2
Routinely held quality meetings? (Q12)	102	65	35	0
Is clinical quality integrated into the business planning process? (Q16)	82	48	49	3

Actions necessary for effective CG

Seven items relate to actions necessary to ensure effective clinical governance and were measured on a four point Likert scale, ranging from 0=never to 3=always.

Table 5-3: Response, mean and standard deviation relating to actions necessary for effective CG

Item	n	Mean	S.D.	Possible responses
Does the Clinical Service use a hospital incident reporting mechanism to ensure adverse events are identified? (Q5)	108	2.89	0.370	Y/S/R/N
Does the clinical service routinely assess clinical risk? (Q7a)	106	2.29	0.873	Y/S/R/N
Does the ‘quality’ meeting recommend changes in how services are provided and ensure these happen? (Q15)	77	2.26	1.044	Y/S/R/N
Does the clinical service routinely put action plans in place to reduce risk to patients? (Q7b)	105	2.21	0.829	Y/S/R/N
Do the results of audits bring about changes to working practices? (Q11)	103	2.20	0.911	Y/S/R/N
Are adverse events openly investigated, lessons learned and changes made? (Q6)	108	2.1	0.831	Y/S/R/N
How often is the quality of record keeping monitored? (Q8)	100	1.74	0.836	Y/S/R/N

NB: scores: 4= yes, 3 = sometimes, 2 = rarely, 1 = no

Overall perception of CG

Seven items create a single scale that obtains a broad sense of the overall quality of clinical governance. These were measured on a five point Likert scale where 1=strongly agree and 5=strongly disagree [Table below].

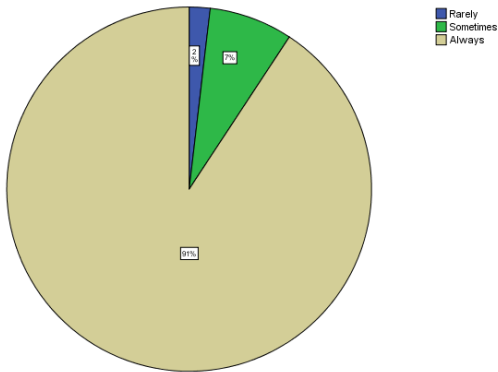
Table 5-4: Response, mean and standard deviation relating to overall perception of CG (Q 17)

Item	n	Mean 1=agree strongly 5=disagree strongly	S.D.	
Evidence-based practice is supported and applied routinely in every-day practice (Q17a)	105	2.3	1.1	
Lessons are learned from complaints and the recurrence of similar problems is avoided (Q17e)	106	2.4	1.1	
Processes for assuring the quality of clinical care are in place in the service (Q17d)	103	2.5	0.9	
Workforce planning and development is fully integrated within the service (Q17b)	103	3.0	1.2	
Clear procedures exist that allow staff to report concerns about a colleague's professional conduct and performance (Q17g)	103	3.0	1.4	
Development programmes aimed at meeting the needs of individual health professionals are in place and supported locally (Q17c)	101	3.0	1.2	
Professional performance procedures that help an individual improve are in place and understood by all staff (Q17f)	101	3.1	1.4	

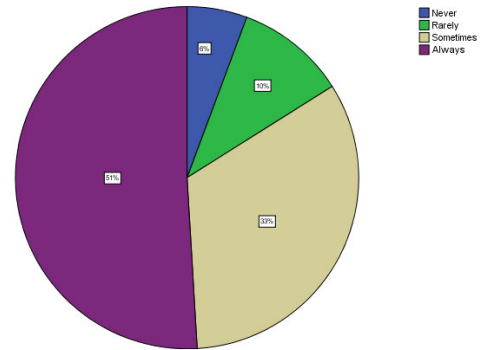
NB Response rounded to nearest decimal point.

Overleaf, a number of pie charts are used to graphically demonstrate some of the key findings from this questionnaire. Of particular note are those relating to the routine assessment of clinical risk; here, only 51% of respondents reported that clinical risks are always routinely assessed. The corollary of this suggests that 49% of respondents believe that the routine assessment of clinical risks is carried out sometimes, rarely or never. It is entirely possible that clinical risks are always assessed routinely, but even the fact that respondents are not aware of this is a cause for concern. It is also noteworthy that only just over one third of respondents believe that adverse incidents are openly investigated, lessons learned and changes made. Again, just over one third of respondents believe that the findings of audits always result in changes to working practices.

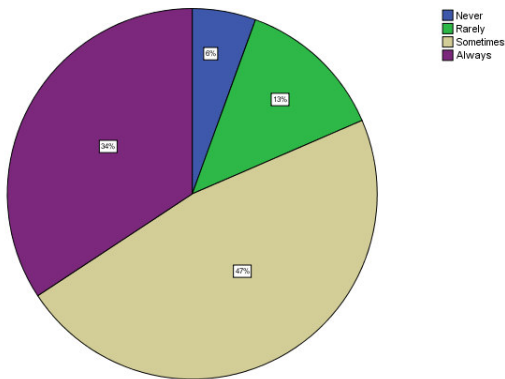
Does the CS use a hospital incident reporting mechanism to ensure adverse events are identified?



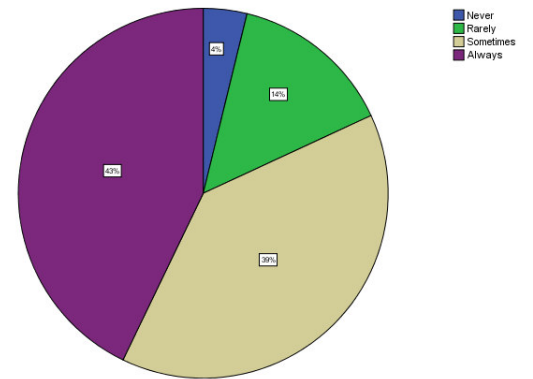
Does the CS routinely assess clinical risks?



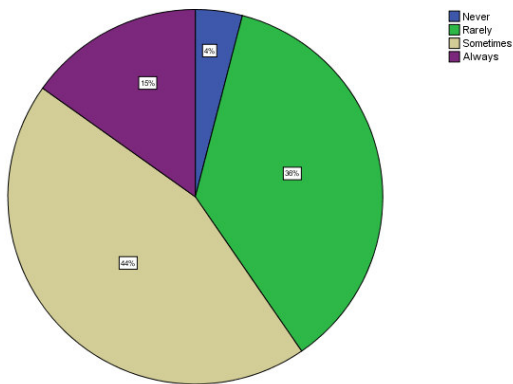
Are adverse events openly investigated, lessons learned and changes made?



Does the clinical service routinely put action plans in place to reduce risk to patients?



How often is the quality of clinical record-keeping routinely monitored?



Do the results of audits bring about changes to working practices

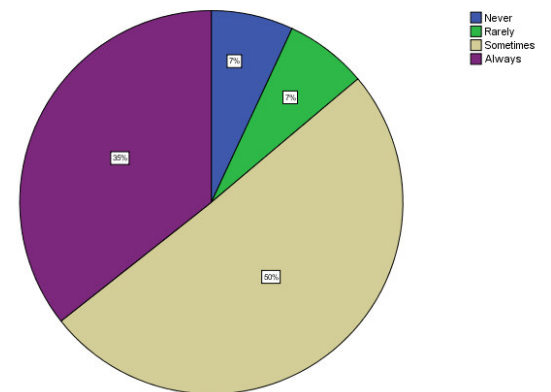


Figure 5-1 Selected CGQResponse PieChart

The Box-plot analysis for CGQ highlights the level of staff respondents' awareness of dimensions of quality management (Sample of box-plots in Appendix B).

Respondents ratings are as follows:

Strong: formal roles in CRM, CA/Programme, and Complaints and Incident Report Mechanisms, Q meetings pursuing change, Q of clinical care in place, and EBP support.

OK: Multidisciplinary Q Meetings, Q Management, awareness of involvement in CA.

Weak: Business planning process, integrated workforce planning, and coordination of clinical effectiveness information, professional performance procedures.

5.1.4 CGCQ

In this instrument, a lower score signifies greater satisfaction in a particular concept. I.e. for positively-stated questions, the scores are as follows: 1 = strongly agree and 5 = strongly disagree (for negatively stated questions the opposite applies). Following Freeman's (2003) treatment of the Clinical Governance Climate Questionnaire, the individual items were aggregated into six factors as follows: Presence of a Planned and Integrated QI framework; Proactive Risk Management; Absence of Unjust Blame and Punishment; Positive Working Relationships with Colleagues; Training and Development Opportunities; and Organisational Learning.

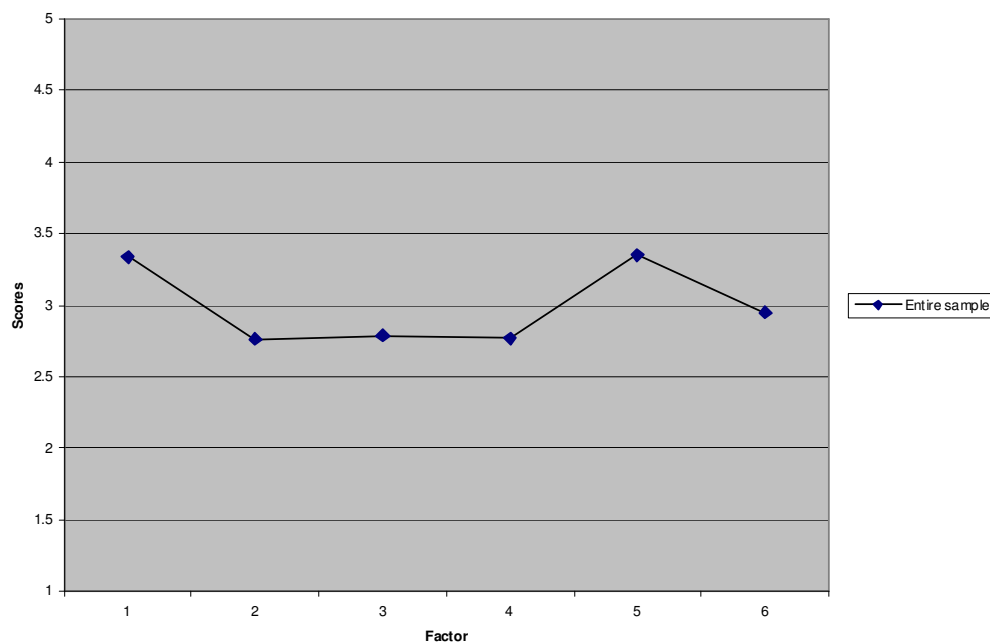
Table 5-5: Response, reliability scores, mean, standard deviation and range of responses from the six factors (score: (1 good ... 5 poor))

Factors	n	α	Mean	S.D.	Range
<i>1. Presence of a planned and integrated QI framework</i> Sample items: (1) People are highly motivated to make changes to clinical practice, (2) Long-term planning for quality improvement gets lost in the day-to-day *	103	0.88	3.34	0.652	1.19-4.95
<i>2. Proactive risk management</i> Sample items: (1) Clinical risks are examined systematically, (2) There is no common approach to risk management	104	0.83	2.76	0.656	1.00-5.00
<i>3. Absence of unjust blame and punishment</i> Sample items: (1) People who make mistakes are supported, (2) When things go wrong, there is an automatic assumption that 'someone is to blame'	104	0.83	2.79	0.807	1.00-4.75
<i>4. Positive working relationships with colleagues</i> Sample items: (1) Colleagues don't seem to understand each others' roles, (2) Everyone has the same standing regardless of professional background	104	0.65	2.77	0.704	1.00-4.67
<i>5. Training and development opportunities</i> Sample items: (1) Technical help with evidence based practice is available, (2) There is no time to reflect on practice	104	0.71	3.35	0.668	1.50-5.00
<i>6. Organisational learning</i> Sample items: (1) We work together across teams to make quality improvements, (2) People devote time to disseminating good practice	104	0.79	2.95	0.864	1.00-5.00

* The full schedule of question items is available in Appendix B3.

The resultant scale reliabilities (Cronbach alpha values) range from 0.88 down to 0.65. While convention suggests avoiding scales with alphas less than 0.7, the proximity of 0.65 as the lowest led us to include retain all scales.

All factors scored in the range of 2.76-3.34 (see figure below). This suggests that individuals were ambivalent toward the presence of an effective clinical governance climate (a score of 3 represents 'neither agree nor disagree'). Factors 2, 3, 4 and 6 (proactive risk management, absence of unjust blame and punishment, positive working relationships with colleagues and organisational learning, respectively) are all slightly positive. Presence of a planned and integrated QI framework, and training and development opportunities yielded a slightly negative response.



Please note that a lower score signifies greater satisfaction in a particular concept.

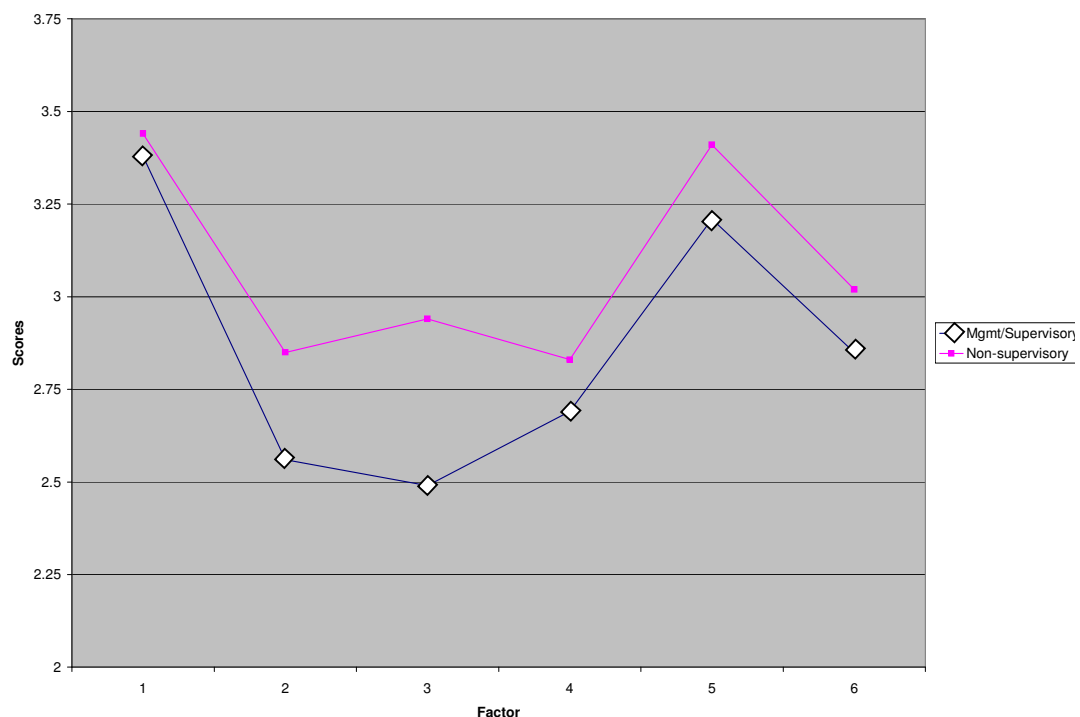
Figure 5-2 Mean scores for each factor overall.

Organisational Levels

In examining the differences in the CGCQ factors across organisational level (supervisory or non-supervisory), the Mann-Whitney-U test was used for Factor 1 and independent samples t-tests were used for Factors 2 through 6. The mean scores for those in management/supervisory groupings versus those in non-supervisory groupings are shown in Table x.

Table 5-6: Mean scores to show trends in responses to each factor in relation to organisational level

Factor	Management/supervisory (n=37)	S.E.	Non-supervisory (n=73)	S.E.
1	3.29 (median=3.38)	.115	3.37 (median=3.44)	.078
2	2.56	.095	2.85	.082
3	2.49	.136	2.94	.093
4	2.69	.102	2.83	.091
5	3.21	.117	3.41	.078
6	2.85	.150	3.02	.103



(CGCQ Factors: 1. Pl/integ QI; 2. Proact RM; 3. Abs blame; 4 work colls 5. T & dev 6. Org Learn.)
(A lower score indicates greater satisfaction in a factor)

Figure 5-3: Mean/median factor scores according to organisational level

Factors 2 and 3 showed significant differences across organisational level as follows: Supervisory staff reported a significantly ($p=0.029$) more proactive risk management (mean=2.56), than did their non-supervisory colleagues (mean=2.86). Non-supervisory staff reported a significantly ($p=0.007$) stronger climate of blame and punishment (mean=2.94) than did their supervisory colleagues (mean=2.49). The differences for the other factors indicated a similar pattern, but did not return as statistically significant. The responses to the individual factors are marked by substantial within-group variation, as evidenced by the histograms in appendix B4 (a).

Specialties (Departments)

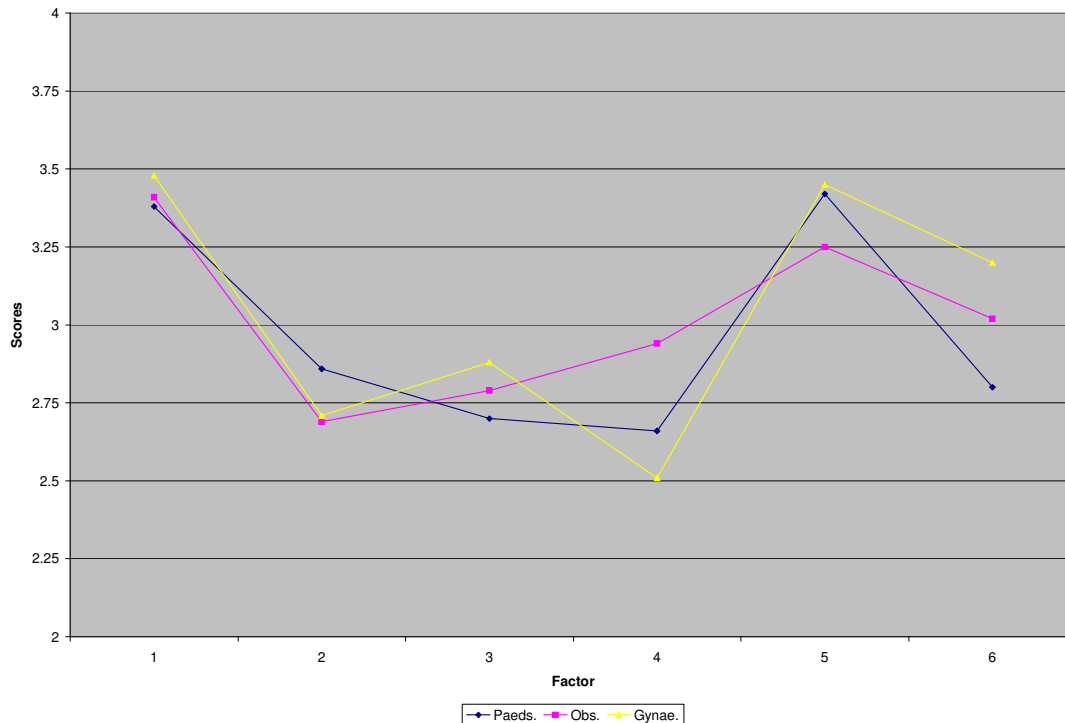
The general trend shows that the various specialties were reasonably consistent in their reporting across the factors, and unsurprisingly no statistically significant differences were found between departments (ANOVA test). However, an examination of Table x and Figure x, which report the means/medians as appropriate of each factor for each specialty demonstrate that the greatest variation was reported in relation to Factor 4, where those who identified gynaecology as their primary discipline reported markedly higher levels of positive working relationships with colleagues that either paediatrics or obstetrics.

Factor	Paediatrics		Obstetrics		Gynaecology	
	Mean	S.E.	Mean	S.E.	Mean	S.E.
1	3.31 (median=3.38)	.120	3.32 (median=3.41)	.091	3.36 (median=3.48)	.163
2	2.86	.134	2.69	.081	2.71	.182
3	2.70	.150	2.79	.107	2.88	.224
4	2.66	.114	2.94	.100	2.51	.202
5	3.42	.113	3.25	.095	3.45	.191
6	2.80	.157	3.02	.115	3.20	.265

(CGCQ Factors: 1. Pl/integ QI; 2. Proact RM; 3. Abs blame; 4 work colls 5. T & dev 6. Org Learn.)

* Median score given for factor one due to non-normality of distribution of data; mean scores provided for all other factors

Table 5-7: Mean/median scores to show trends in responses to each factor in relation to specialty and role category



(CGCQ Factors: 1. Pl/integ QI; 2. Proact RM; 3. Abs blame; 4 work colls 5. T & dev 6. Org Learn.)

Figure 5-4: Mean/median factor scores according to specialty

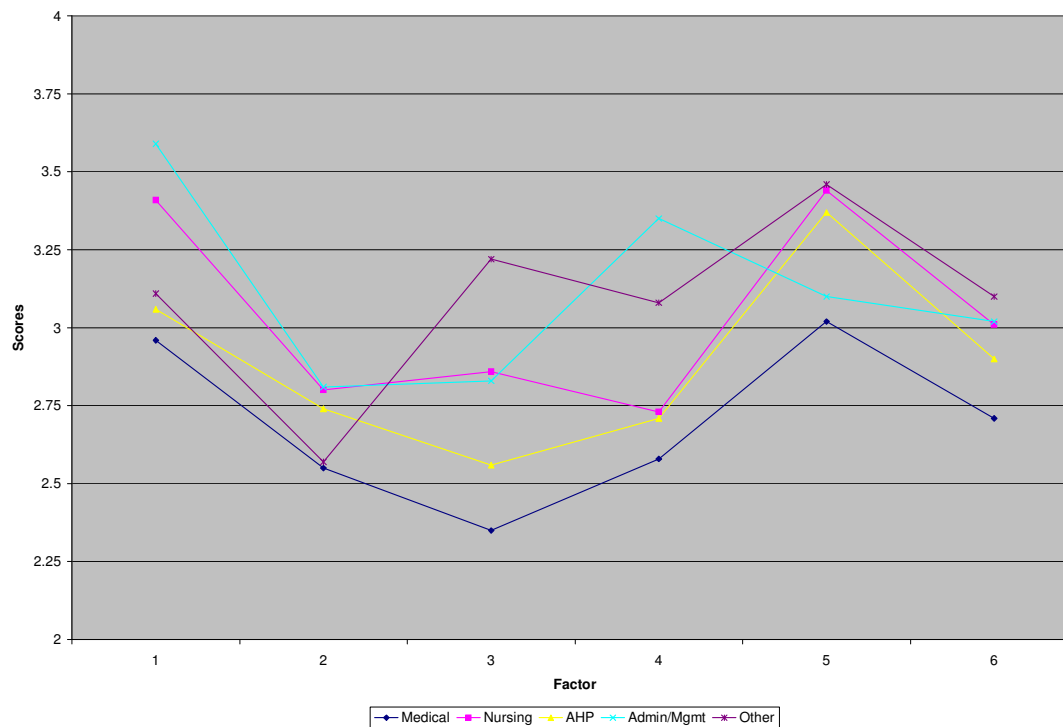
Roles

In relation to role category, again no statistically significant differences were found. However, this is not surprising given the number of respondents relative to the number of role categories, as well as the large variation in the number of respondents from each of the role categories.

However, in examining trends, it is clear that there are marked differences between roles in response to factors 3, 4 and 5 in particular. It is also interesting to note that those in a medical role are most positive in relation to all factors of the clinical governance climate. Whether this is because, they are more highly trained and more aware of clinical governance concerns than their non-medical colleagues, or that they are simply less aware of the deficiencies in the clinical governance climate than their non-medical colleagues, is unclear.

Factor	Medical		Nursing		AHP		Admin/Mgmt		Other	
	Mean	S.E.	Mean	S.E.	Mean	S.E.	Mean	S.E.	Mean	S.E.
1	2.96	.231	3.41	.069	3.06	.156	3.59	.141	3.11	.528
2	2.55	.253	2.80	.076	2.74	.256	2.81	.116	2.57	.145
3	2.35	.221	2.86	.099	2.56	.108	2.83	.166	3.22	.386
4	2.58	.200	2.73	.074	2.71	.520	3.35	.164	3.08	.556
5	3.02	.234	3.44	.077	3.37	.231	3.10	.113	3.46	.251
6	2.71	.293	3.01	.104	2.90	.208	3.02	.167	3.10	.320

Table 5-8: Mean/median factor scores according to role



(CGCQ Factors: 1. Pl/integ QI; 2. Proact RM; 3. Abs blame; 4 work colls 5. T & dev 6. Org Learn.)
(A lower score indicates greater satisfaction with the factor; 3 = neutral)

Figure 5-5: Role Category Responses by CGCQ Factor

The Box-plot analysis (again ref appendix B) of CGCQ data indicates a variable climate related to some items. Respondents rate as follows:

Very good: Error reports, CR information, help with EBP, colleague's honesty, Risk Assessment update and learning from failure.

OK: Sharing a common vision, mutual responsibility in contributions, and emphasis on 'how versus who'.

Not so good: Critical appraisal training, standing regardless of profession, anticipation of accidents, and assessment of development needs, 'there is someone to blame'.

Poor: No protected time or long term planning for QI, time to share ideas and priority of pressure over QI.

5.1.5 Resonance between CGCQ and CGS

The possibility is posed of resonances between Climate (CGCQ) and Governance (CGS) responses: in the table below, each CGS item is associated with the CGCQ climate factor with which it appears most closely related. The data did not allow a strong comparison, but some interesting correspondences can be seen.

Within the climate factors, the strongest responses related to Risk Management, Working with Colleagues, and Absence of Unjust Blame. Then came Organizational Learning, and followed by Presence of QI programme, and Learning and Development Opportunities.

There was a widespread awareness of Risk Management (Proactive RM 2.76; 88% could identify an individual responsible for RM). People were very positive in the factor Working with Colleagues (2.77) and this resonated in people's confidence to identify individuals with responsibilities in this area – for Setting Quality Standards, for Clinical Audit, and for Complaints (all high). People were less definite in relation to Workforce Planning, and Coordinating Clinical Effectiveness Information (both 'medium'). The strength of factor Absence of Unjust Blame (2.79) resonates with 'procedures for reporting concerns' ('neutral'). The neutrality of the factor Organizational Learning (2.95) contrasts with 'agree' for EBP routine and lessons learned from complaints.

The larger proportion of CGS responses was associated with the factor 'Presence of an integrated QI Programme'. The overall climate score was low (3.34; 1=good, 5=poor)), but there was a wide variation in corresponding governance scores

– people were very aware of the existence of CA for example (82%), but proclaimed a lower score for involvement and multidisciplinary in decisions and especially for achieving change. Scores were ‘medium’ for CA involves all clinical staff (69%), Q meeting multidisciplinary (67%), meeting for quality issues (65%). Scoring poorly (rarely) were: Routine assessment of Clinical Risk at 2.29, as were items relating to achieving change, rated at the ‘rarely’ level: Q meeting makes changes (2.26), Clinical risk reduction plans (2.21), CA changes work practices (2.2), adverse events openly investigated (2.1). The attention paid to monitoring clinical records is low (1.74). Only 48% said quality was incorporated into business planning.

Training and development opportunities constituted the weakest factor (3.35), and this resonated with neutral responses for associated items - development programmes to meet individual clinical service needs, professional performance support, integrated workforce planning/development.

In general, people seemed to be able to identify more closely with an individual (responsible individual responsible for ...) than with some support processes like workforce development with which they might not normally be closely involved.

5.1.6 Comments on CGS Instrument

The CGS has a mixture of rating scales, and question style which proved to be unsatisfactory both for respondents and for data analysis and interpretation.

Respondents found the level characterisation confusing, in that job titles included the word ‘manager’ whereas the job was in fact more ‘supervisory’ within the respective discipline. This would need to be resolved in future. Also, many questions contained more than one underlying concept.

In hindsight, there are better options to be considered that are modelled on validated international instruments.

Table 5-9. Resonance between CGCQ factors and CGS variables – on aggregate.

CGCQ Factors	Overall Rating	CGS Status	Grade	Level
Proactive Risk Management? (Quality Management)	2.76*	(4a) Individual responsible for Risk Management	88% yes	High
Working with colleagues? (Clinical Directorate)	2.77	(4f) Individual responsible for - setting service quality standards	87 % yes	High
		(4b) Individual responsible for - CA	86 % yes	High
		(4c) Individual responsible for - Complaints	84 % yes	High
		(4d) Individual responsible for - w/f planning	72 % yes	Medium
		(4e) Individual responsible for - Coordinating clinical effectiveness information	71 % yes	Medium
Absence of unjust blame (Constraints)	2.79	(17g) procedures for reporting concerns	3.02 ⁺	Neutral
Organisational learning? (Performance Mgmt)	2.95	(6) Adverse events/ lessons are learned...	2.1	Rarely
		(17a) EBP routine	2.29	Agree
		(17e) lessons learned from complaints	2.37	Agree
Have a QI programme? (Quality Management)	3.34	(5) risk – incident reporting	2.89	Sometimes-rarely
		(17d) Q assurance processes-clinical care?	2.48	Neutral/agree
		(7a) clinical risk – routine assessment?	2.29	Rarely
		(15) Q meeting makes changes?	2.26	Rarely
		(7b) Clinical risk reduction plans?	2.21	Rarely
		(11) CA changes work practices?	2.2	Rarely
		(6) adverse events – open investigation?	2.1	Rarely
		(8) monitor Q of clinical records?	1.74	rarely/never
		(9) CA programme?	82% yes	High
		(10) CA involves all clinical staff?	69% yes	Medium
		(14) Q meeting multidisciplinary?	67%	Medium
		(12) meeting for quality issues?	65% yes	Medium
		(16) Q issues input to business planning?	48% yes	Neutral
Training and development opportunities? (Performance Mgt)	3.35	(17c) Development programmes – to meet individual-clinical service needs	3.03	Neutral
		(17f) professional performance support	3.10	Neutral
		(17b) integrated workforce planning/dev	2.99	Neutral

Scales are as follows:

* 1 = strongly agree with a positive statement, or strongly disagree with a negative statement (lower is more positive ie 1 = “very good”, 2 = “good”, 3 = “neutral”, 4 = “poor”, and 5 = “very poor”)

⁺ 1 = no (never), 2 = rarely, 3 = sometimes, and 4 = yes (always)

Commentary based on full response set.

5.2 Document Analysis:

The arrangement of documents according to intent (espousal) and realisation is set out below in Figure 5-6 and these are now described briefly.

Strategy

The focal document for GUH QI activity is GUH Strategy 2006-2010. It defines the hospital's Mission as follows:

Galway University Hospitals (University Hospital Galway and Merlin Park University Hospital) aim to provide high quality and equitable care for all its patients, in a safe and secure environment, and to achieve excellence in clinical practice, teaching, training and research.

The hospital's core strategic objectives are defined as Clinical Services, Research, Staff and Education. Quality activity is located as within the supporting set of strategic objectives, together with Capacity, Alliances, Governance, and Innovation (p 17). The hospital's Vision is stated in terms of six dimensions: Service, Dignity and Respect, Education, Research, Communication, and Quality. Fundamental to realising these objectives is a participative OD-inspired developmental process.

Hospital quality improvement is elaborated in more detail in CQI Strategy, and the associated documents Healthcare Risk Management Strategy and Policy, and Clinical Audit Policy.

Structure

GUH Organisation Structure and Function organisation charts detail relations at a high level down to Directorate level. Coordination activities are detailed in EMT and HMT terms of reference, Job descriptions for CD Director and Business Manager. Service Plans are presented at HSE, Hospital and Directorate level indicate planning process, and the place of plans in subsequent performance monitoring and accountability processes. Refurbishment is described with reference to W&C Directorate i.e. Gynae Theatre and St Monica's Ward.

Planning

The GUH IS Workplan outlines the state of GUH ICT systems, its formal planning processes, and issues surrounding these including 16/97 planning (DoF Circular 16/97, 1997). It also indicates elements of GUH ICT strategy. The 16/97 process aims

to provide standard and accountable planning, monitoring and control processes for ICT expenditure in the public service, and is outlined in a separate government circular. Integrated Care Pathway (ICP) Development Planning describes a standard multi-step developmental process adopted from the NHS UK by GUH. An example is given for an ICP (Paeds Tonsillectomy-Adenoids-and-Grommets, TAG). A substantial Annual Training Plan is produced for the hospital, based on a widely canvassed Training Needs Assessment. The delivery of the Training Plan is described in the HR Annual Report.

Process

In Obs-Gynae, the extensive ISO Quality Manual is the primary source of quality structure and processes, all clinical and service procedures adopted, referenced and implemented at ward level in Obs-Gynae. In Paeds there is a set of controlled clinical guidelines and protocols at ward level. Both Obs-Gynae and Paeds demonstrate strong evidence of the hospital-wide accreditation in respect of documentation in their departments. Formal minutes of QI groups record these departments' compliance with the accreditation process.

The formation process for CDs is described in five stages. This incorporates a participative OD process. Several examples of paper-based communications to engage staff in the formation of directorates, and the accreditation process were noted eg Quality Bulletin. It is noted that a web-based staff information system is coming on stream.

Outcomes

There is a substantial set of outcome documentation: eg W&C CD Annual Report, W&C Incidents Report, HR Annual Report, supporting PIs for OG and Paeds, Staff PIs (HR Dept), HIPE (IS Dept), and general hospital-level activity/utilisation data.

Evaluation

The Accreditation Report published in June 2008 represents the strongest form of evaluation. This presents a comprehensive statement on the development and maintenance of policy and procedural documentation for the hospital. This may be deemed complementary to the present report.

Periodic CD reports to EMT address progress on relevant projects in the hospital service plan, including those originating in QI activity. Progress is referenced to HSE Corporate Objectives. Summary results from earlier accreditation evaluations (eg IHSAB 2002) were presented as supports for Service Planning.

GUH Patient Comment cards, and HSE ‘your say’ complaints cards are an important part of the review process. They indicate two perspectives: comment cards appear to capture a wider range of information than the complaint card, which takes dissatisfaction as a starting position. A list of completed Clinical Audit projects indicates progress of CA Policy. The report of the Clinical Directorate Workshop (Friday 14th Sept 2007) is most important, in that it is an assessment by staff engaged in the formation of the directorates at all levels. The aspects examined were entitled: What’s working well?, What’s not working well?, Moving things forward, A suggested plan, and Summary of actions agreed.

Indeed, the staff and community engagement approach taken by GUH has already attracted praise from the National Partnership Forum as a national exemplar of good practice in progressing “new ways of working and value for money” (NPF Annual Report 2004, p22).

Figure 5-6. Governance with respect to Organisation Level and Activity (intent and realisation)

Activity \ Level	Level	Ext to GUH	GUH Organisation		Provider		Patient	
			Hosp/Functions	CD/Dept	Clinicians	Staff	Individuals	Community
Intent	Strategy	Quality & Fairness HSE Corp Plan Reform '03 Transformation	GUH Strategy CQI Strategy RM Strat & Pol CA Pol		Med Board CQI Committee RM Committee CA Committee workshops	DN(n/mw) CQI Committee RM Committee workshops		
	Planning	HSE SP 16/97	ISIT Workplan Serv Plan '07 16/97 plan Training Plan	CD SP Shadow budget?	Training Needs assessment Perf plan (form)	Training Needs assessment Perf Plan (form)		
	Evaluation	Accred Reports IHSAB/HIQA OHM-CIM	HR: ISO (HR), HSE Best Employer?, O2 Ability Award Other (3rd) ISO?	What Works w/s Baby Friendly Award ISO (OG)	Perf assessment (form)	Perf assessment (form)	Patient satisfaction Comment card t/b	
Realisation	Structure	(Statutory and Professional Bodies)	Org Charts: GUH (to CD level) & Funct./Depts EMT terms of ref HMT terms of ref RM Cttee & role CA Cttee & role ICT Tools	Job Spec CDir Job Spec Busn Mgr WTEs/Staff list Refurbishment (Gyn) 6 beds Paeds Baby security sys ...	ICPs Assumed Prof Job specs	ICPs Assumed Prof Job specs	DN as Complaints Officer/ Patient Representative	Outreach- MidWife Clinic Travellers Clinic
	Process	ISO 9001: 2000 (rev03) IHSAB/HIQA ACAS 2nd ed.	Q Manual: Guidelines, protocols, procedures	F/w for CD Mtgs Q Manual Paeds Guidelines/ procs OG Clin MW/N Glines OG Safety Pols/Procs OG Q Pols&procs	Clinician schedules Clinical Audit 5-step CD Formation Clin review mtgs Protocol review RM feedback Orientation eg to Accreditation	Labour Ward Forum Protocol review RM feedback 5-step CD Formation Orientation eg re Accreditation	Patient Comment/ Complaints Feedback	Focus Groups (eg Galway Focus)
	Outcomes		Incidents, claims, Litigation HR Annual Report / Training Pls Patient Activity Vols Clinical Pls (no Hosp AR) ISIT dept Pls	Pat Activity Vols Clinical Pls Incident Report CD Report to EMT CD Ann Rept 07	HIPE Clinical Audits		Patient Comments/ Complaints Discharge summaries Notification eg births	

5.3 Qualitative Analysis:

The qualitative data analysis resulted in two templates – ie A and B (see Figure 4-1. Development of Qualitative Findings”). Template A reflects the prime emergent themes (CD structure, performance, quality, constraints, and change) that are adopted for triangulation with the document analysis and the quantitative study.

Template A provides the basis for the triangulation structure in section 4.4 (in narrative form). The overarching categories in Template A are: clinical directorate, performance management, quality management, constraints and change. They structure the data in an analytic framework with sub categories and properties. For example, in relation to the clinical directorate the sub categories are formative influences, perceived purpose, scope, role, reporting relationships, status, and leadership, while properties for one subcategory e.g. leadership are style, limitations, and dimensions. This facilitated the integration of all relevant data fragments in the first analytic report (Template A, Appendix D).

Template B (Appendix D5) is a further distillation of the qualitative findings from Template A. This Template B highlights important dimensions such as leadership, management, CD role and functions, performance management, quality management, and change priorities. This provides a summary of insiders’ narratives from their experience. The main categories are as follows:

Leadership (HSE, GUH past and present and CD) style and clinical leadership. The HSE corporate style is centralist and directive, not unlike GUH in its past. The present GUH approach is participative and seeks a cohesive governance structure. The CD team is democratic and service- and quality- oriented with positive individual characteristics indicated. While clinical leadership is in evidence at CD and ward level, there are limitations that relate to organisational culture and residual effects of hospital management style in the past. There is a strong rationale to engage clinicians in management yet it took significant time to achieve full commitment, although agreed with the Medical Board.

Management (characteristics and constraints).

Management is portrayed with reference to resource, performance and quality management. Capability is not supported by management training for CD roles. HSE

management capability and training is weak. The scale of the organisation has removed power from local administration. A lot of flexibility is gone and local management has been undermined. Micro-management and low levels of morale are associated with this situation. All levels report the absence of a specific budget and a lack of control of staff numbers

CD role and functions (positive and negative indications of progress).

The CD structure is associated with devolved authority, good teamwork and unity enabled service and quality improvement. The intention was to have a budget and financial control. The reported CD functions are to plan, implement and report, improve the services and manage people. This contrasts with reports of limited awareness of the change, buy-in, recognition and blurred roles and dual reporting, more layers of management, limited scope/authority and control, and in communications, unity and multidisciplinary teamwork.

Performance management is reflected in roles, resources, standards, and data. The ISIT constraints at national and local levels affect performance capacity and capability. There are positive indications regarding progress in OG re data, standards setting, and information systems that support decision processes and problem solving. This is in stark contrast with Paeds. GUH has limited performance indicators. There are plans to improve this through HSE Service Plans and targets. Overall more investment is required to enable self-regulation and control.

Quality management is based on a hospital-wide strategy and support structure. There is no specific model in use. There is leadership from the CQI committee that links to CDs and the Medical Board. It is clinician-led but its range of activities are limited. While quality is on the hospital agenda it does not appear on the CD agenda. At CD level the QI team meets monthly. The Business Manager and Clinical Director are responsible for quality in the CD.

The Clinical Risk Management Committee has CD representation and input into clinical risk and patient safety agendas. CD ownership is emphasised. There are weekly reviews at CD meetings and the Labour Ward Forum.

Clinical Audit is mainly medical. There is evidence of some audit activity in O/G e.g. perinatal mortality and caesarean sections. While there is an interest in clinical audit

there is an insufficient number of CA projects in evidence. The O/G Dept has ISO since 1996. It has generated good policies and procedures and an effective documentation process. It facilitated the transfer to accreditation. Q Pulse is being introduced. This has implications for ISO use and extension. There is a hospital-wide commitment to the accreditation process as a catalyst for improvement. It has facilitated team working and placed quality on everyone's agenda. The process is generally reported as very beneficial. There are some reservations at unit level. Hospital perspectives suggest that quality is very good, for example the Steering Group had a huge impact, or in contrast that quality is not yet embedded in day-to-day business. O/G in W&C Directorate is especially recognised for progress in quality and risk, with high ratings and good feedback reported. Its Annual Clinical Report is exceptional although there is no formal benchmark such as occurs in Paediatrics' neonatal service (Vermont-Oxford).

Change Priorities?

The reported priority to enable CD performance from all levels emphasises the need for a budget, staff control and information. Improvement is sought in management training, communications and participation. The CD structure should be formalised nationally and given substance. It is hoped that the CD will push clinical leadership and clinical governance with clinician buy-in to produce quality data for planning.

The foregoing provides a brief aggregated insight from four GUH levels. A fuller text is available in Appendix D.

The primary qualitative data is reported through Template A's full text analysis (appendix D1). The derived narrative provides the structure for data triangulation with document and quantitative data in the following section.

6 Triangulation

The following text aligns the three data sources thematically. The presentation addresses each of the major questions posed in the interviews (re CD, Performance, Quality, Constraints, and Change). Subsidiary sections address the major themes that emerged within each question from the analysis of interview transcripts.

Each of these sections opens with a description of relevant documentary evidence of intent and practice (typed in Arial font), followed by the themes emerging from the qualitative analysis (in Times New Roman Font), in turn followed (and/or interspersed with) outcomes from the quantitative surveys where available and relevant (in *italics*). Within the qualitative analysis, the numbers and letters, within parentheses, refer to the organisational level from which the comments emerged, as follows:

1 = Hospital Management

2 = CD Management

3 = Dept Management O: Obs/Gyn; P: Paeds.

4 = Ward/front line level O&P

1: CLINICAL DIRECTORATE:

Formative Influences: (Hospital & CD Mgt)

[Doc] In hospital documents, the CIM model is treated as synonymous with CD model. As a basis for design, GUH-Strategy references two Deloitte & Touche reports on GRH management structures from 1999 (Deloitte & Touche, 1999, a, b).

Influence on CIM model from the System level resonates to Q&F. HSE documents are less specific. Reform 2003 is concerned with “devolving accountability for spending to the most appropriate decision-making level” and making clinicians personally accountable for cost as well as clinical performance. They should be fully brought fully into planning, management and control processes. Finance and performance are the key focus of attention but the CD model is not explicitly mentioned. The Corporate Plan 2005-8 refers to a Code of Governance, without specific mention of CDs, and “ (the) adopt(ion of) a strategic and business planning

approach based on best evidence". Transformation refers loosely to 'clinical leadership and team-based service delivery' (e.g. Prog6, staff).

The GUH Strategy 2006-10 places CIM model to the forefront of the hospital's way forward. It was formed in a participative and wide-ranging programme. It is worth noting that the formation of Mission and Vision were lauded as an important example of joint problem-solving in the Partnership Annual Report of 2004.

[Qual] There are attributions of external and internal influences. The former refer to national and international evidence that CDs work (1, 2) and that the system wants them (2). The latter refer to inadequate arrangements in the past e.g. Heads of Department and Clinical Co-ordinators who did not have formal authority and accountability in a centralised structure without clinician input (1). Hospital Management initiated the clinicians in management project. It is intended to facilitate hospital-wide integration and enable participative decision structures and accountability (1, 2).

[Quant]. Not available.

Perceived purpose, scope & role

[Docs] The CD in Medicine newsletter states the purpose of the CD/CIM structure is to serve as a basis for conjoining clinical and managerial decision-making, close to where clinical activity takes place. The job descriptions for Clinical Director and Business Manager indicate that their prime objectives are to: deliver the annual service plan at CD level, provide a link among specialities in CD, and between specialities and the hospital, report to EMT and HMT, manage resources provided and not to deviate from the budget, run meetings, deliver bi-monthly reports to EMT, promote cooperation with hospitals, services and healthcare providers, deliver on RM, Complaints, CA, HIPE, and to control WTE staffing, and deliver CQI programme, to support CA, benchmarking and PIs, and accreditation. Clearly, quality is central to this agenda.

The workshop "What Works" indicates positive outcomes – chiefly revolving around better communications, and also some negative experiences such as unclear boundaries, lack of budget and real decision-making.

The Framework for a Clinical Directorate defines CD structure in terms of a formal statement of recurring meetings with scope and frequency.

[Qual] Clinicians are close to the patient and have direct service influence. Their input to and awareness of service issues and the high level of their spend, points to the need for ‘self managed’ CDs (1). In the past, such involvement would have caused them fear of compromising their patient care (1, 3). A more accountable and cohesive governance structure is envisaged (1). CDs will have local ownership of performance management with a budget, staff control and management of service quality and its improvement (2,3P,4OP).

***[Quant].** Currently, there appears to be a lack of clarity around what exactly the CD is responsible for. For example, 88 percent of staff members believe that there is an individual within the CD responsible for clinical risk management, but the other 12 per cent believe there is not. Only 72 per cent of staff members are aware of the presence of individual responsible for work force planning. It also appears that those in higher levels are more aware of the presence of such individuals, but this finding is not statistically significant.*

CD Scope/Logic (Boundaries)

[Doc] Documents seen do not specify the rationale for clustering into CDs. However, reference is made to Deloitte & Touche reports of 1999 on GRH organisational structure. The What-Works Workshop (WWW-CD-2007) indicates some difficulties have been experienced over activities passing inappropriately outside CD boundaries.

[Qual] CD boundaries reflect historical relationships, rationalisation goals and the scope and scale of units (1). These have implication for CD learning and manageability. The accountability lines still go to the GM and Professional Bodies (1).

The combination of O/G & Paeds in W & C is based on historical links and needs (1, 2, 3P, 4). “We were doing it except we didn’t have the title” (2b). The model was endorsed having observed a UK site (1.3P). Some see the decision as arbitrary but recognise the need for some link (3.OP). The CD terms of reference are defined at a senior level and are intended to empower so as “to manage within constraints” (1a). However, people are unaware of the terms of reference at departmental level (3.OP).

CD Functions and reporting relationships

[Doc] The CD reporting arrangements are contained in a number of documents (see Appendix x):

The GUH Hospital organisational chart is supported by departmental charts, without specific reference to CDs, for the following: Deputy General Manager's Office, Director of Nursing Department, Finance Department, HR Dept, Information Services Dept, Quality a& Risk Dept, and Services Dept. and function organisation charts.

An amalgam from the documents is shown in figure 1-2 (page 14). The main feature is the complexity of reporting arrangements required to sustain the CD, and the dual lines of authority of each individual on the management team.

[Qual] CD functions include resource management (3.OP) and service planning (1). That extends to sharing problems and communications with Paeds (3.O), improving service standards and performance and in dealing with needs and issues (3P.4P). The Director reports to the EMT through the GM (also interacts positively with peers) (1). Team members are accountable to the Director (2) with decisions referred to HMT and EMT (1) reporting to those levels (2). 4.OP). There are dual role-relationship issues regarding the DGM and DN.

***[Quant I].** It appears from the data that there is a general sense that staff members are reasonably positive toward the experience of working with their colleagues (mean =2.77). Though there are no statistically significant differences, the trends are that supervisory staff would generally score more positively on this than non-supervisory staff. Also when examined according to role category, it appears that medical staff members are most positive toward their colleagues and admin/management grades are least positive.*

***[Quant II].** Awareness (80%+) of person designated for setting clinical service standards, Risk Management, Clinical Audit, and Complaints. Awareness (70%+) of person designated to workforce planning and coordination of clinical effectiveness information.*

Control.

[Doc] There is no discussion of the 'soft side' issue of control. Clinicians have a say in selection of the C Director, as peers, and there is a monthly clinician meeting to which the ADoN and Services Rep (AHP) are present as observers.

Formal control for operational duties, as opposed to professional duties, is centred around performance, including service planning. In managing relationships, it is not clear from documents what sanctions/influence forms are used/available, whether within or without the CD. Union relations are identified as a problematic issue in specific context of CDs in WWW-CD-07, and in the HR annual report.

[Qual] At present, control is located at hospital and HSE levels (1). In addition, consultant independence (2) is a challenge to the authority and accountability of the Clinical Director (1, 2). Unification is slow even if there is good teamwork (1). The CD is described as two departments merged (1) 'exist as two departments' (4P) and the gradual engagement of Paediatrics in the CD is noted. (3.OP). There are problems regarding recognition by unions (2) and professional bodies (3P). CD management assert that there is unity, good meetings & feedback although cross-disciplinary working is mainly for medical policy and guidelines (2).

[Quant] none available.

Leadership style

[Doc] The job specification for Clinical Director lays down the need for both clinical and managerial leadership capability and attitude: 'lead and manage', "coordinate ... implementation", "manage resources", "organise and chair meetings", "advance the unification of GUH", "promote cooperation with other hospitals...", "Facilitate ... CQI programme".

The job specification for the business manager focuses on coordination. The Clinical Director and Business Manager receive some basic training in management processes, though there is an indication in WWW-CD-07 that this is insufficient.

[Qual] The leadership style is democratic and team based (2). Two members are described as very persistent, another is a good communicator who has a very strong

work ethic, is quality orientated and sees the big picture. They are all very service and quality orientated (3.O). There are barriers to leadership, such as traditional directive style (1) unions (3.O) and layers of management (2).

Clinical leadership is either “definitely there”, “good with some subjectivity” (1) “trickles down” or “comes from the ward”, “you can feel it on the ground floor” (2, 3.O, 4.O). But, “unfortunately, the culture of this organisation does not really have any arena for good leadership” (3.O). “For years it was confined to higher management of the hospital” (1).

[Quant I] *There is a significant relationship between organisational levels in terms of their perception of the existence of a blame culture. The direction of the relationship suggests that the lower one is within the organisational hierarchy, the greater the perception that a climate of blame and punishment exists ($p=.007$).*

[Quant II]. *Neutral re perception of procedures for reporting concerns about professional colleagues.*

2: PERFORMANCE MANAGEMENT

Performance management is seen as central to HSE policy and strategy: Reform 2003, Transformation, and the Corporate Plan 2005-8 strongly promote it for accountability, integration, efficiency, coherence and response. All these resonate with Q&F 2001, which is a central plank of the GUH Strategy, and runs down through EMT, HMT terms of reference, and job specifications for Clinical Director and Business Manager, and Suggested Mode of Operation of a Directorate (annex to Clinical Director job specification).

The Corporate Plan (HSE-CP-05/7) has a special section, in addition to the Four Objectives, devoted to Accountability and Performance Management. Their aim is to connect the vision of Q&F with business planning, performance monitoring and accounting through all levels – national SP, hospital, and departmental. The envisaged frequency is monthly for operational control, and annual for external reporting i.e. performance and financial report.

Service planning, with associated monitoring and review processes (eg HSE, Hospital, CD) is the central integrating framework for decision-making and control. The key constraints for decision-making and control are financial Vote and WTEs.

As a basis for performance monitoring framework, the Plan references a National Performance Indicator suite which is not disclosed. The SP document refers to objectives, resources, WTEs, corrective actions, and in particular to performance, rather than quality, and these form the central focus of control.

IT and IS

[Doc] The main source document is the GUH IS Work-Plan for 2008. The National Information Strategy was published in 2004. Though near completion, publication of HSE ICT strategy has been constrained by uncertainties in project leadership (email MM to SdB Aug 08). GUH has representation on the group overseeing the development of a National Hospitals' Information System, but the status of the supplier was a source of grave uncertainty in 2007, and a constraint on progress. In the absence of strong central leadership, the hospital has adopted a de-facto strategy, based on expectation and emergence of national direction.

The IS Dept has shifted focusing to developmental from operational activity, supporting Departments and Directorates to develop their own key users to handle and be accountable for their own data. Routine IT support is placed on managed service contracts, and project management capability is being developed (eg through Prince II). The de-facto strategy focuses on infrastructure development, and integrating islands of software as applications and hardware come up for replacement or new investment. The development of a single electronic medical record is a central task, which focuses on national developments, and on local practicality in context of existing GUH applications and needs.

Risk, efficiency (less paper, less paper handling), and access form key justification criteria. Access to information is critical for clinicians ('only what I need when need it'; now), for patients (e.g. information leaflets), information for GPs eg prescriptions, HIPE data for casemix-based payment and for planning, confidentiality and security.

The Workplan identifies gaps between intended IT structure, and the present situation in the context of underpinning high quality service and performance. An outline of software applications and hardware in GUH shows the need for substantially more integration and a strategy to address this when replacing or investing in new facilities. There is a shift in priorities from operational to strategic, planning and developing technical and human IT capability, moving routine advisory/direct support work to managed service contracts. The development of project management skills at client dept level is a prime example.

In Obs-Gynae, the core application *Euroking* has worked well for 14 years, but is due for update. Its replacement must address its disadvantage as an information island, isolated from the newly emerging integrated system.

The CD forms a useful locus for communication and development, enabling development of IT skills at local level empowering departments, and focusing technology responsively with respect to dept needs and hospital and system priorities. W&C is an exemplar in this regard, with its long established tradition in Obs-Gynae, its wide range of PIs in daily use, and its service support developments eg discharge documents.

There is a Data Quality (DQ) programme in place, and there is a move to a data warehouse structure to underpin access to multiple applications, along with investment on a new enterprise-level high speed network back-bone.

IS expenditure is controlled centrally through a "16/97" process (ref government policy in regard to IT investment, "circular 16/07"), and this is cumbersome (IS-WP-07), but it has the great benefit of forcing better thinking.

[Qual] Inadequacies at National IT level necessitated local initiative and engagement with some IT role distribution to hospital units (1). There are references to STARS, EuroKing, Q Pulse (3) and an evolving Dashboard (1). There are reported local deficiencies e.g. Finance, HR, Medical Records, HIPE limitations and restricted CIS with some exceptions (1, 2, 3.OP).

In W&C, CIS works with IT and is quite good (1, 2, 3.O). It needs an upgrade but could become the national standard (1). Paeds are very low in technology (1) with information consequences (3P).

Clinical information is crucial! , “my clinical data was most helpful to me in analysing the issues and trying to ascertain where the priorities lay” (2a) but some clinicians have limited use of data (3P).

Performance

[Doc] HSE-CP-07 references a National Performance Indicator Suite.

Organisational functions produce PIs on their activity. Eg HR provides monthly a list of PIs relating against targets to numbers receiving training, participant satisfaction ratings, staff absenteeism, and so forth. IS produces Dept activity PIs. As for quality per se, the IS Dept is working with Directorates on developing PIs relevant to their disciplines.

The W&C-AR-07 demonstrates that they use a wide range of performance indicators of their choosing (OG-AR-06, W&C-AR-07). These include patient volumes by department and by diagnosis/treatment category. In W&C, there is a designated person (MH) who coordinates, produces and presents the corresponding reports using applications supported by IS.

CDs report performance with respect to SP bi-monthly to EMT and to HMT (Reporting Template).

HIPE is a core data source (IS Workplan; “What Is HIPE”) eg for diagnosis/therapy volumes, LOS. It uses ICD-10AM. The IS Workplan indicates more use could be made of this source, and there is inadequate capacity for coding, with a sustained substantial backlog.

At Corporate level, performance is managed through the Performance Management Unit in Dublin (HR AR).

Performance management of individuals is focused on goal-setting in the form of Personal Service Objectives. Forms contain fields for detailed statement of specific areas, objectives and actions, and an account of progress and achievements.

[Qual]: There are some Performance Indicators agreed for some specialities. It is planned to develop them through a national project and the service plans. However, “they are difficult to implement when I look at my own level of performance (WTEs)” (1a).

Activity targets are devolved. W&C set action plans, measures and outcomes and have a reasonable handle on their activity and performance (1).

Performance Management is under-developed and under-invested so that real self-regulation is limited. EMT monitors CD performance (1) but there is a view they “don’t really measure for results” (2c).

W&C is progressing. It is (the CD Model) “getting going philosophically as a combined Directorate” (1a), and there is “general agreement on the Directorate Model” (2a). The CD characteristics are “good”, “very good teamwork”, “unity”, “good relationship with staff” (2) and very innovative, cohesive and patient focused (1b). There are service improvements (2, 4.O) and increased activity (2). There is more to be done as there is a low level of CD awareness and impact at the front line (4.OP). Communications need to improve “need better communication from Director down...” (4P).

[Quant I]: *One potential reason that performance improvements may be difficult to implement could relate to the relatively low level of organisational learning evident. In general, staff members appear ambivalent to the presence of organisational learning (mean =2.95). Though not statistically significant the trend in scores suggests that according to specialty, those working in obstetrics perceive the lowest level of organisational learning and in relation to role category, those in admin/management grades perceive the highest levels of organisational learning.*

[Quant II]: *Agree EBP Routine and lessons are learned from complaints. Lessons rarely learned from adverse events.*

[Quant I] Though there is clearly an awareness that performance must improve, there appears to be a general perception amongst staff members that opportunities for training and development are reasonably limited (mean=3.35). Interestingly, this perception varies significantly across organisational level, with those in managerial/supervisory position perceiving training and development opportunities to be greater than those in non-supervisory roles.

[Quant II] Neutral on existence of development programmes to meet individual clinical service needs, professional performance support, and integrated workforce planning.

3: QUALITY MANAGEMENT

[Doc]: The espoused quality model is defined in CQI Strategy, Healthcare Risk Management Strategy 2006, Clinical Audit Policy 2007, ICP policy. It corresponds with the Strategic Objectives Quality and Governance in GUH Strategy 2006-10.

It is strongly influenced by the Acute Care Accreditation Scheme Standards and Guidelines (ref IHSAB ACAS 2nd ed.). ISO 9001:2000 (revised 2003) at Dept level is held by Obs-Gynae Dept since 1996. Developments on quality reflect the feedback from earlier accreditation visits (see appendix 1 attached to CQI policy), and ACAS demand for verifying written evidence of process: accreditation is an explicit plank in the GUH strategy to raise the quality, performance and growth agendas.

The risk management model is strongly informed by the Aus/NZ 4360:2004 standard and previous experience eg in Health and Safety. The importance attached by the hospital to RM is indicated by the very large RM orientation programme for all staff in 2006.

[Qual]: There is no formal Q Model in use. There is a combination of Q approaches and fora (1.2.3OP). One perspective is that “Quality talk tends to be about improving service and not quality” (3.Oa) and for another, “standards are my own personal experience...” (3P).

There are strategies and plans for Q (1, 2). “The GM message is that Q is in everything” (1k). While some say that Q does not go on the CD agenda (2b, 3Oc), others disagree or associate it with the development of guidelines and procedures (1, 3P).

[Quant I]: *The average score across all staff members in relation to the existence of a planned and integrated QI programme was 3.34. This suggests rather dishearteningly that the average sentiment was that staff were responding more negatively than positively to the presence of such a programme. Potentially, even more worrying is the range of responses, which indicates that some staff disagree strongly that a planned and integrated QI programme exists.*

[Quant II]: *Awareness (80%+ i.e. high) CA programme! Q issues as input to business planning (48%). Neutral/agree: quality assurance of processes for clinical care. Sometimes: risk incident reporting. Rarely: routine assessment of clinical risk,*

quality meetings to make changes, clinical risk reduction, CA changes work practices, adverse events open investigation. Rarely/never: monitoring quality of clinical records.

Q Structures

[Doc]: EMT is accountable through the GM to the Network Manager. It defines and implements the structures of the hospital, including setting up and reviewing the work of hospital committees, and the relationship of the directorates with HMT, and is accountable for “the utilisation of resources and the provision of an efficient and effective quality service, which is patient-centred and achieves value-for-money, as agreed in the GUH annual service plan”.

HMT is the principle hospital forum for managing delivery of the strategic vision of EMT. In 2004 (HMT Terms of Reference 30th Sept 2004).

At hospital management level, there is a Quality and Risk Department, a CA manager, an ICP Coordinator and Risk Advisors.

The Director of Nursing is designated as the hospital Patient Relations Manager. In the HR Dept there is a Learning and Development Manager.

There are well-defined hospital committees for quality, who report into EMT, as follows:

CQI Steering Committee:

Departments, including OG and Paeds, are represented.

Reporting to the Steering Committee are Sub-Committees, each with formal terms of reference): Multidisciplinary Policies & Procedures Committee (~7 members); ICP Development Committee (~ 6 members); Clinical Audit Committee (clinician-led, and –constituted, ~ 12 members)

Risk Management Steering Group.

There are two Risk Advisors who liaise with the CDs.

There are several Sub-Committees: Health & Safety, Equipment Hazard Notification group, Occup. Health, Manual Handling, Infection Control, Medicines Safety, Blood Transfusion Committee, Resuscitation Group.

At CD & ward level, Risk Registers are maintained, and there is a forum to discuss risk issues at least monthly (eg CD meeting and Labour Ward Forum).

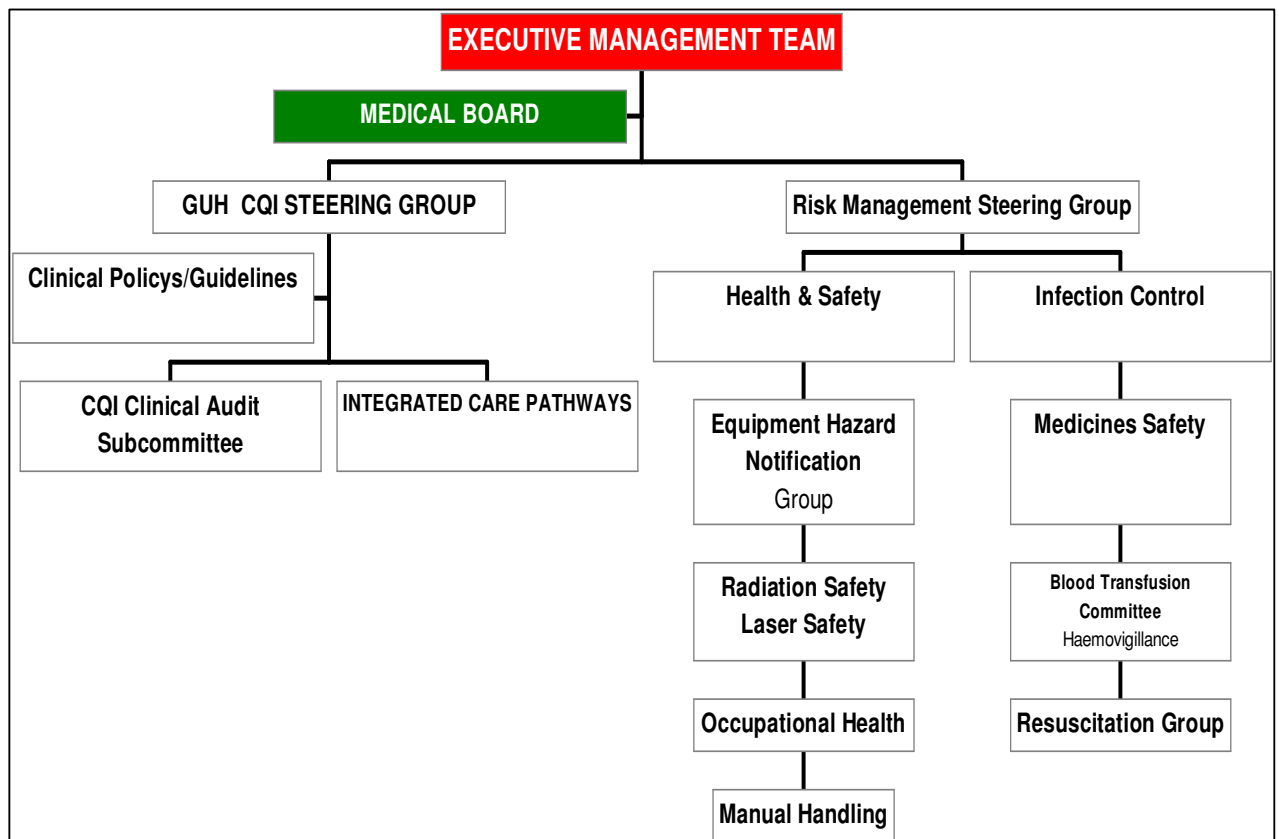


Figure 6-1. Quality and Safety Framework for Galway University Hospitals (CQI Strategy)

The CD Quality Coordinator reports to the BM, and liaises with all depts, levels & categories within the CD.

[Qual]: The Q structures include the *CQI Steering Committee*. The CDs nominate representatives and submit issues to it. It examines multi-disciplinary policies and procedures (1). The Chair links to the Medical Board. It is very clinical-led, 2 years ago it would not have happened (1j) but it can only pick small areas at a time (1k).

In W&C, the Director and BM have responsibility for managing Q. The QI team meets monthly (3.OP).

The *Clinical Risk Management Committee* has a W&C Rep (2) and input to CR and Patient Safety (3P). The Clinical Director provides an overview of risks and

addresses them (3P). There is a very active risk group who produce policy, procedure and reports (1). RM needs a dedicated person otherwise it comes back for follow up (2).

RM reviews take place weekly with the GM (1j) and monthly Q meetings (2b) , at CD meetings (2b, 3Pa) and in the Labour Ward (or more frequently) (3.Oa).

[Quant:] *It appears from the data that there is a general sense that staff members are reasonably positive toward the presence of proactive risk management. In fact it was the factor that was most positively scored in general. However, there is a statistically significant difference across organisational levels with those in managerial / supervisory positions reporting greater proactive risk management than their non-supervisory colleagues.*

[Quant II]: *Awareness (60-70%): CA involving all clinical staff, Q meeting multidisciplinary, meeting for quality issues.*

[Qual] At the Labour Ward Forum all disciplines` discuss issues e.g. risk and recurring topics (3.0). The monthly *Clinical Audit (CA)* Reports and Reviews include Caesarean Sections and Perinatal Mortality (3). There is a need for improvement in CA. Hospital Management observes that there is insufficient CA; at best it is selective and primarily medical (1). Departmental Management confirm that it is mainly medical and some “don’t audit as such” (3P). In any case “Ireland is very poor in auditing outcomes (3P).

ISO in Obs-Gynae has very positive recognition in the management of Q since 1996 (1, 2, 3O). It facilitated the transfer to Accreditation (1). The Accreditation Group will decide about if for Paeds (3.0P). The benefits from ISO are in the systematic management of Q (3Oa), comprehensive good policy and procedures (2.3O) and internal Q Audit standards for compliance and correction (3P).

Accreditation’s positive dimensions relate to multi-disciplinary teamwork, development, training and putting Q on everyone’s agenda (1). Its self-assessment process flags up deficits in policy and guidelines (1) and highlighted good points and

deficiencies (3P). There is a commitment to (1) and pre-occupation with Accreditation (2).

Alternative perspectives on Accreditation indicate that, “it has no impact on practice” (3P) “not hugely impressed- site visit didn’t engage clinicians or women...” (3.O); “an overwhelming process...” (3P).

Q Management Overview

[Docs]: Promotion of quality activity is channelled through CQI Steering Committee, with quality written into all job specifications, quality-driven procedures, protocols and guidelines, a special Q&R department at hospital level, and support from HR (structure, change management, training/education), from IS for gathering quality-related data (application development, specialist users at dept level) in a quality manner (eg Data Quality project). Quality is essential part of the job specs of Clinical Director & Business Manager, and Q activities are built into the workings of CD (method of working of a CD). The CQI Steering Committee incorporates and complements RM Committee activities. Patient-Community input is provided through Galway Focus, and a number of special focus group projects. Hospital strategy is informed by a participative style incorporating the interests of a wide stakeholder base, as evidenced in GUH Strategy for the Future 2006-2010. A participative organisational development pervades major changes, in particular the formative development process for CDs (ref 5-stage CD Formation Cycle; ‘What Works’ Workshop, W-WW-CD-07).

Many very detailed documents attest to substantial on-going QI activity in the Directorate. The Self-Assessment Team Summary Profile Report prepared by the W&C QI Team for Accreditation 2007 shows volumes, PIs, incidents, QI plans and improvements. There is a W&C response to each of the 17 IHSAB Care Standard. A well-used laminated risk rating sheet demonstrates rating in everyday use. Version-controlled lists referenced by Obs-Gynae Q Manual contain Clinical Midwifery/Nursing Guidelines (182), Safety Policies & Procedures (50), and Quality Policies and Procedures (48).

A review of minutes of quality committee meetings demonstrates staff commitment and the quality of tasks undertaken e.g. for accreditation.

Patient advocacy is a core activity. The Director of Nursing is the designated Patient Relations Manager, a role which combines statutory duties of hospital Patient Complaints Officer. The hospital initiated a Customer Comments process, and this complements and facilitates the statutory complaints-handling process. It is notable that the GUH comment card system captures much more feedback than arises solely from complaint, and this yields a stream of positive changes on the ground.

A sample W&C Incident Report lists incidents arising in the period 31st October 2007 to 29th Feb 2008. These are categorised with frequency and severity. The bulk of the moderate and high risk cases are attributed to Treatment Incident, Other, and Perinatal incidents. Costs data are not assigned to incidents in the directorate (e.g. clinical negligence claims).

The QI Committee processes a substantial number of project proposals. These have fed into Service Plans at CD and Hospital levels, and into the IS 1697 submissions (ref DoF Circular 1697 planning procedures for Government IT expenditures).

An arrangement of the list of QI projects by intent (strategy, planning and evaluation) and by realisation (structure process and outcomes) is presented in appendix C2. This indicates considerable process-level and evaluative activity, with strategic direction focused on Paeds. Structural changes are reported in the form of the Risk Register implementation, and physical refurbishment (though of a holding nature in Gynae).

A large staff training programme in Risk Management is reported (30x1½ hour training sessions, 1600 attendees in 2006).

Substantial Clinical Audit activity is reported for W&C (Breastfeeding audit & re-audit, audit of 3rd Degree Tears & re-audit, audit of Neo-natal Admissions, Baby Temperature audit, Audit of Supplements Given to Children, Hysterectomy ICP audit, Paediatric DNAs (did not attend), CPR Trolley audit).

[Qual]: Regarding Q Management in general, the CQI Steering Group has made a huge impact. It is very good (3P, 4P). W&C is doing well (3.O). The CD has a very strong team (1). It is very effective and better than most (2). Nursing

standards are extremely high (Paeds) (3P). OG score high on listening to patients. It has made inroads to Q (3P) and has come a long way in Q & R and contributed to a Q patient-centred focus (1).

Benchmarking is primarily connected with Paeds. The Vermont/ Oxford database enables international comparison on Q and Outcomes in neonatal care (2.3).

[Quant]: The MARQuIS survey points to a high level of quality activity, with peer professional review, and ISO and “other” active pursuit of accreditation and re-accreditation. While this activity is not at full strength in all departments, however, apart from staff issues (eg turnover, absenteeism), a wide range of performance indicators, covering both utilisation/operation and clinical indicators, is on both management and clinical agendas. Performance is regularly reviewed, and consequent action taken to develop services in response to feedback, even if this activity is not fully systematic in all areas. While there is very little actual collaboration of patients in developmental work, patients views are taken into consideration. Systematic quality improvement takes place in ‘some’ departments, and internal audit in ‘most’. The survey noted absence of regular staff performance reviews, but the documents show forms for carrying this out indicating the system is either in place or coming on stream. No benchmarks were available for MARQuIS.

4. CONSTRAINTS

External

[Docs]: Reform '03 and the HSE Corporate Plan proclaim fragmentation as a core system constraint. Weaknesses in planning capability (eg service planning) is attributed as a major constraint in pursuit of the goal of a unified and accountable system.

HR Annual Report '07 notes that the activities of the HSE PMU place a large burden on hospitals to provide data to their request, and this constrains other work. IT Work Plan '08 notes considerable disruption to training schedules resulting from pre-emption by HSE corporate staff.

[Qual]:

HSE: Management & Control

There are major concerns about management capacity and the extent of central control in the HSE.

Many managers are nominal and are more staff advocates the decision makers. Being time-served rather than being trained and developed is a management selection criterion (1). There are inefficiencies and layers of management (1). The top-down, centralised style has removed local power and flexibility and limited GM decision authority (1.3O). “HSE is hugely micro-managing the system” (3P). Service Plan targets are dictated by the HSE (1). Paradoxically, “the HSE don’t want any change” (1) and local managers can’t make changes (1). The consequences are that it is “managed by resources and unions (1k), local management are undermined (1), “motivation is being eaten because we are constrained with the environment of the HSE (3.O). Because of the embargo there are fears of non-replacement (3.O).

HIQA

Their standards create more pressures (1)

Internal

Limited Budgetary Devolution and Control

[Docs]: The WWW-CD-07 workshop has identified lack of budget control, control over decisions on allocation of WTES as key obstacles to CD performance. The W&C Annual Report notes absence of promised shadow budget.

[Qual]: There is an emerging scepticism (3P). No budget and no control over staff numbers! This resonates through all levels of GUH/CD (1, 2, 3OP, 4OP). For example, Finance never devolved the budget” (1) it has not yet set any budgets for the Directorate (2); someone in Finance is looking into it! (2). Regarding staffing issues, they don’t know the level of vacancies or the costs or control over staff numbers (4.OP). They want to develop new governance structures but are under-resourced (1). “At the moment our whole lives are hinging around two things- WTEs and bed capacity” (1).

Ownership and Control

[Docs]: The IS Work Plan ‘08 notes reluctance of departmental staff to take on responsibility for signing-off on information generated in departments. The HR Annual Report ‘07 notes a disappointing uptake of training, especially as the content offered was identified by a participative training needs assessment.

[Qual]: CDs have yet to take full ownership and management. “I empower others, but yet I am expected to have the answer- nobody likes making unsavoury decisions” (1b). A corollary is the consequence of hospital management having to engage CD input in preparing reports for the HSE and deal with issues raised (1).

In contrast, CD and Departmental management say that CD Authority and responsibility is very limited (2.3.O). “There is limited control over what we can do” (3Pa). There is no scope to solve problems, change services or anything that might influence (3.O). The GM decides priorities and the EMT ultimately make the decisions (2). Things are not devolved down to the level of Directorates- it is still back to GM (3P). It is more direction than discussion (4.O) so people need to start letting go (2).

There are complaints about the status of the new CD structure from all levels (1, 2, 3, 4). There is not a huge buy-in from all stakeholders (1). There is resistance on the ground to a clinician in charge and it is not clear if nursing has taken it on (1). They still have a close working relationship with all ADNs (1). The Nurse line is dual (CD & DN) so that there is an operational blur (1). The BM who is expected to be all things to all people but the role needs to be reviewed (1). Another shared view is that there are more layers of management! (2) another layer to go through/ between clinical staff and management (3.O); a lot of layers in the system and more difficult to get decisions (3P). There are also too many nurse managers (4.O). There is little evidence of training for the Clinical Director or BM (2).

5: CHANGE (expectations/requirements)

[Doc]: The Clinical Directorate Workshop, “What Works and What Does Not Work” is the prime document with respect to suggestion of changes to the CD structure and ways of working from a staff perspective. In it are highlighted for attention: communication lines with sub-management levels in Directorates; communications vertically with hospital level, the CD budget and control over WTEs within the CD, management training for Business Manager and Clinical Director, dual linkages, and porous boundaries (I.e. there are activities going on outside the CD that should perhaps lie within it).

[Qual]: Change expectations relate to control, clinical governance, capacity and capability, and structure, management, facilities/staffing generally.

Budget and Control

[Docs]: Reform '03 and the HSE Corp Plan have proclaimed, towards the goal of unitary control and reduced fragmentation, a need for better service planning and control at hospital level, reinforced by improved accountability, especially of clinicians for the financial impacts of clinical decisions, team-work, and involvement of patient voice in service developments in setting service goals at all levels.

At hospital level, accreditation visits (02, 04-06 ref appendix I in CQI strategy) had earlier identified Service Planning, and a Utilisation Management Programme as important deficits requiring attention.

CD operation is premised on the early deployment of a “shadow budget” (see “method of working for a CD” in CDir job spec).

[Qual]: There is a significant call for more localised control from all levels (1, 2, 3.OP, 4P). This focuses primarily on the budget eg full involvement, autonomy, more support and power, flexibility and the need to reward people for change (1); responsibility for spend. The call is for devolution otherwise it is a pseudo-Directorate with HMT allowing unions not to acknowledge the Directorate (2). “When we get a budget we will make more strides, (3.Oc), manage our own affairs; these things need

to be in our hands (3.O). The required combination is to own the budget, have staff control (4P) and more information and autonomy (1, 2).

Clinical Governance & Leadership

[Doc]: Clinical Governance is subsumed in the broad QI/RM agenda. “Governance” is a firm component of GUH Strategy for the Future 2006-10.

[Qual]: Clinical Governance (1, 2, 3.O) needs more clinician buy-in (1), clinical leadership (3.O), more general involvement (2) and pro-active reporting of incidents (2).

Capability & Capacity

[Doc]: The CD Workshop (WWW) flags the need for more training for the Business Manager and Clinical Director.

[Qual]: The role of Clinical Director needs to be formalised nationally and given substance (3). In addition the 2 units have to be combined to gain efficiencies (3). Management training (3.O) and better communications from Director down is necessary with opportunities for more input (4P). Facilities, staffing levels and bed capacity have also to be improved (4P).

7. Prospective: Next Steps

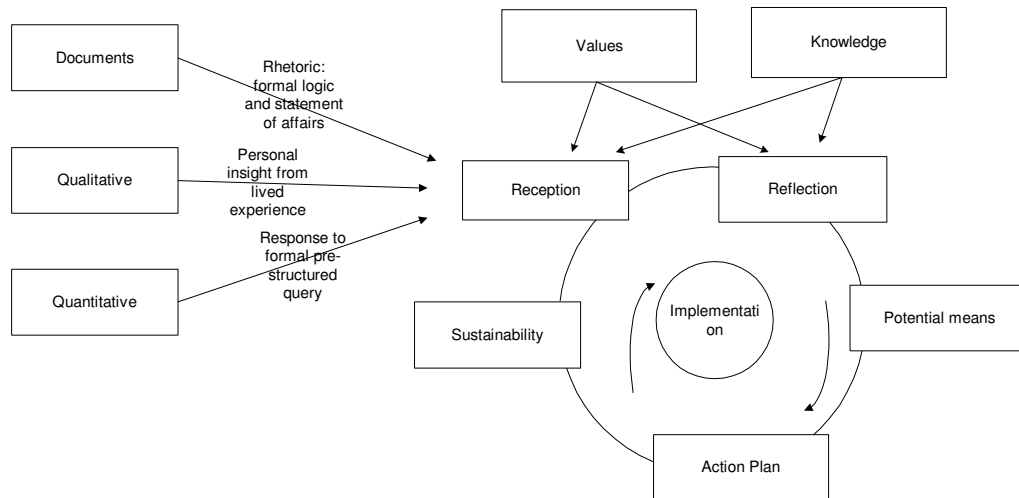


Figure 7-1: Next Steps

This Mapping Study provides a baseline or reference point for reflection on the intent of policy and procedure and the realisation of same in practice. This mirrors the organisation's espoused theory and theory in use and can lead to a grounded basis to adjust or modify in a contextual learning process. That will relate to values, leadership/followership, attitudes, capability, capacity and knowledge/information. It will clarify and support the what, who and how of GUHs trajectory.

A suggested approach in moving to the reflective phase is undertaking the following:

1. Identify the incongruities between policy intent and external and internal influences with the reported reality of experience and dominant perceptions.
2. Engage various levels and disciplines in reconciliation and review exercise based on the triangulation material ie documentary, qualitative and quantitative findings under thematic headings.
3. Compare results of Mapping with the extant literature.
4. Consider benchmarking vis a vis MarQuis and WHO-PATH and comparable service units and arrangements.

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Appendices

A. Quality frameworks

A1. Framing Quality – general

1. Human Reliability Stream

As a parallel strand to industrial quality, the ‘human error’ / human reliability tradition is crucial. It derives from accidents in heavy industry, transport and aviation in general, and in particular the control operation of chemical and nuclear-power plant. The publication of ‘Unsafe at any speed’ (ref the Ford Corsair/Pinto; Nader, 1960), and ‘Acceptable Risk’ (Fischhoff et al., 1981) have attracted sustained attention to the inherent dangers of high technology. ‘Normal Accidents’ (Perrow, 1983) locates the roots of catastrophic failure in organisation structure and culture, and especially in complex, tightly-coupled processes with non-linear outcomes. Leplat (1987) demonstrated boundary of responsibility as locus for incidents. Reason (1990) shows human error characterised by ‘mistakes’ and ‘slips’, rooted in knowledge-, rule- and skill-based cognitive activity, and how this propagates in conducive settings to yield catastrophic results. Vicente (2000) provides an interesting analytical overview, and Casey (1990) provides some interesting case studies of a more general nature: The Challenger disaster (weak personal influence of expert), Bhopal (starvation of funds), Vinchristine errors (non-recoverable medicinal administration error; wrongful litigation against nurses) are textbook examples.

Robustness can be designed into safety systems. In particular the positive experience of the Air Safety Reporting Scheme (ASRS) sets an archetypal model for centralised safety-proofing, with widespread canvassing for actual incident cases, confidential and anonymous treatment, and feedback of root cause analyses to the operator and designer communities in a systematic fashion. Untangling messy problems with very high stakes requires motivation: Bristol (Bristol, 2001) referred to the inherent problems of relying on a legal department for leadership in examining systematic problems thus driving problems deeper underground. This is obviated in the ASRS scheme.

2. Quality Mechanisms

What is Quality? ‘Fitness for Use’ is an enduring benchmark. Shiba (1993) defines quality in terms of five fitnesses: fitness to specification; fitness for use (customer satisfaction in any reasonable use); fitness for cost; fitness for latent needs; and fitness for society (environment, future generations). The measurement and management of Quality clearly requires a multi-dimensional frame.

2.1 Quality Control (QC)

The term “Quality control” carries many meanings and is used variously to mean point process control, system-wide quality assurance (compliance to product specification), and total quality management (focus on continuous improvement through structural adaptation in response to customer satisfaction and market opportunity).

2.2 Statistical Quality Control (SQC)

Statistical QC provides a representation and language adapted to the practical purposes of industry and the aptitudes of the actual people working there, and provides a scientific evidence base for decision. Classical texts like Grant and Leavenworth (1st ed 1942, 4th ed 1972) frame QC in terms of Shewhart Control Charts and Acceptance Sampling. Emphasis is on assessment at a point. Statistical tools are the essential means to identify in the “noise” of variation, the variation that is important in terms of controlling a treatment process, resulting in reliable streams of product outcome. Measurements are presented in a form that is understood by industrial managers and workers (who are appropriately trained), and this enables productive discussions to take place to improve situations that go out of control and so forth. Quality Control is exercised ‘for the purpose of preventing production of defective units’ (Hayes and Romig, 1982, p 10). Quality control is related strongly to the discipline of Engineering Reliability, which traditionally extends the analysis to failure in time domain, and thus to product life. Origins and idiom of Reliability lie in production of electrical products. Dhillon (2003) provides a mapping of reliability engineering to healthcare delivery.

2.3 Quality assurance (QA)

QA is an organisation-wide administrative framework directed at the capability of a large organisation to consistently achieve and show that it has achieved specified product properties (eg p43 Wadsworth Steven & Godfrey, 1986). Internal audit is introduced. Johnson states (1970, p.19): “Discipline is the key to quality.

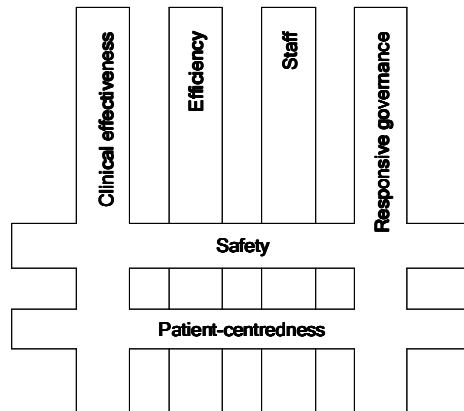
Evaluations... determine the extent of a contractor's ability to implement and maintain the self-controls necessary to administer an effective quality assurance program." Emphasis is on processes and their overall compliance at an organisational level, including supply contractors. Economic argument (cost of control/failure of control) is central to justifying effort.

2.4 Total quality management (TQM)

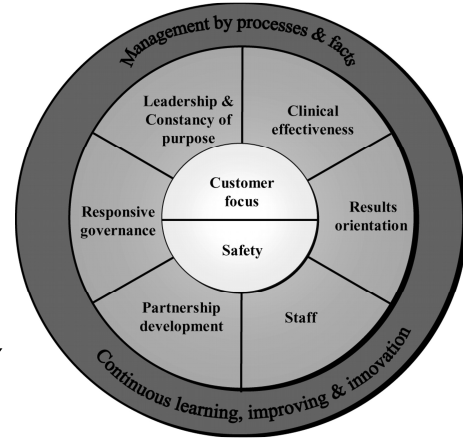
TQM has been credited with adding systemic improvement. In texts, the Seven Tools of Quality Management started to appear widely in the early 1990s. TQM is associated with Company-Wide Quality Control (CWQC) elements of the 'scientific thinking mechanism' in the Toyota Production System (Shingo, 1988). At the roots of TQM are the standardisation, planning and control elements of Scientific Management (Taylor, Gantt), the statistical process control methods of Deming, Juran and others disseminated in the years after WWII, and a holistic dual perspective of product/customer experience and resource experience, considered in equal measure, and focused on the elimination of waste. Thus TQM builds upon the rigour of statistical QC and explicit discipline of QA, utilising data-informed, human-centred and customer-centred opportunity-spotting and problem-solving, with perpetual incremental improvement the norm (PDCA, the 'virtuous cycle' of continuous improvement). Key is a 'double-loop' learning, a programmed on-going organisational learning (improvement), that enables ever-tighter capability to be achieved. The developmental activity is drawn in, almost naturally, by evidence, especially statistical quality/performance data, and is supported by sound and substantial practical analytical capability both in operating personnel (eg in Toyota everyone gets at least a one-day training in statistics), and from support provision (eg industrial engineering dept, and specialists in each area). A core contribution in all of this is to bridge the gulf between shop-floor voices and top management (Shingo, 1988). Culture is recognised as central. The result is responsive conformance and innovation, not just conformance to arbitrarily imposed standards of mixed relevance. Improvement relies heavily on, and demands, a fertile informational and organisational ecology.

A2. Quality Framework Diagrams

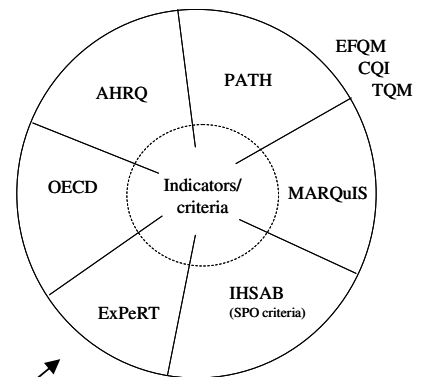
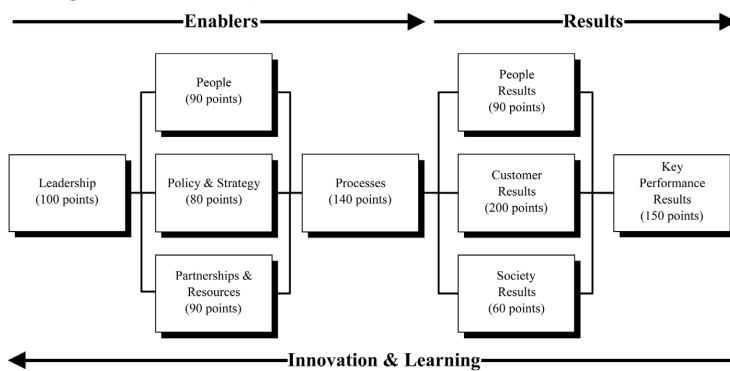
PATH Veillard et al (2005)



PATH-EFQM Vallejo et al (2006)



EFQM EFQM (1999)



All routes lead to standards, indicators/criteria

OECD Mattke et al (2007)

Healthcare systems performance How does the health system perform? What is the level of quality of care across the range of patient care needs? What does this performance cost?					
Dimensions					
	Quality			Access	Cost/ expenditure
Health care <u>needs</u>	Effectiveness	Safety	Responsiveness/ Patient centredness	Accessibility	
Staying healthy					
Getting better					
Living with illness or disability					
Coping with end of life					

B. Quantitative Surveys

B1. Full Survey Population census.

Legend: straight numbers are as per list of named staff as per nov 2007;

(numbers in brackets are as per “WTES for Women’s and Children’s Directorate as of may 2007).

101108

Count of Dept		Dept					
Level	Cat	CD	G	O	[OG total] (OG)	P	Grand Total
L 1	Admin			1(1)			1
	AHP	1(1)					1
	Med			1(1)			1
	Nurs/MW			1(1)			1
L 1 Total		1		3			4
L 2	Med		2	2	[4] (5)	5 (4)	9
	Nurs/MW		5 (6)	28 (24.5)	[30]	5 (4)	38
L 2 Total			7	30	[37]	10	47
L 3	Admin		1(1)	13 (7)	[14] (15.85)	7 (4.5)	21
	AHP	7 (6.5)		0 (1 teen)			7
	HCA		7 (15.5)	8 (8.8)	[15] (23.3)	3 (2.15)	18
	Med		13	(1rad)	[13] (13.5)* ¹	11 (10)	24
	Nurs/MW		50 (47)	153 (84.2)	[203]	52 (29.25)	255
	Other		4	2	[4]	2	8
	Med_st		1	3	[4]	2	6
L 3 Total		7	76	179	[253]	77	339
Grand Total		8	83	212	[290]	87	390

*¹ reg + sho+ clin tutor

Response %

Overall	freq	avail	
total	111	390	28.5%

Levels	freq	avail	
Level 1 + Level 2 Managerial & Supervisory	37	51	72.5%
Level 3 Non-supervisory	73	337	21.7%

Specialties	freq	avail	
Paeds	37	87	42.5%
Obs	54	212	25.5%
Gynae	13	83	15.7%
Total	104	382	27.2%
Missing / CD	7	8*	

* 8 AHPs operate at CD level.

Role Categories	freq	avail	
Medical	15	40	37.5%
Nursing/Midwifery	74	294	25.2%
AHP	4	8	50.0%
Admin/mgt	10	22	45.5%
Other	6	26	23.1%
Total	109	390	27.9%
missing	2		

Category X Level interactions

(cells <=6 excluded)

	Levels 1&2	Level 3	
med	40.0%	36.7%	37.5%
NursMW	69.2%	18.4%	25.2%
AHP			50.0%
Admin			45.5%
Other			23.1%
Tot	72.5%	21.2%	27.9%

Letter from Professor J Morrison, Clinical Director, to staff re participation in survey. November 2007.

**To: Members of Staff, Women's and Children's Directorate,
Galway University Hospital.**

**Research Project Information Sheet
Women's and Children's Health Clinical Directorate GUH**

Dear Member of Staff,

The Women's and Children's Directorate at Galway University Hospital have linked with the Health Services Research Department at the University of Limerick, with the common aim of carrying out a study in relation to Directorate structure and its implementation of operation and procedure, and the perception of the members of staff in relation to this.

What is the study about?

This study will map the Directorate's current approach and progress in the development of policy and practices that contribute to its performance in providing a quality service.

How will this be undertaken?

A collaborative group representative of the Directorate's two key service areas, i.e. Obstetrics, Gynaecology and Paediatrics, and a research team from the University of Limerick. This team has expertise in organisational change and quality improvement from the Health Systems Research Centre, the Enterprise Research Centre and the Strategic Health Management Research Group, KES in the University of Limerick.

When will the study take place?

The survey will be conducted during the period 12th to 23rd November 2007 to ensure that staff on rotation will have an opportunity to participate. In some instances, a full staff survey will be undertaken, depending on numbers, whereas a random sample will otherwise be necessary to keep the load within workable bounds. A questionnaire is enclosed and when completed may be returned in the pre-addressed envelop to Ms. B O'Malley. Paediatric staff can return the completed questionnaire to Ms. Ann Matthews for collection. These will then be forwarded to the research team in the University of Limerick for analysis. The case study will be informed by a preliminary survey analysis and is scheduled to occur mid December, 2007 to mid January, 2008. Document analysis is already underway.

This is a very important survey. The questionnaire will take approximately fifteen minutes to complete. The purpose of this information leaflet is to inform you about this on behalf of the team at the University of Limerick and the Directorate.

With best wishes,
Yours sincerely,



Professor John J. Morrison,
Clinical Director,
Women's and Children's Directorate.

8th November, 2007

B2. Summary of MARQuIS survey results.

Context:

Hospital Structure: Public, University hospital 1039 Beds; [Med(410), surgery (441), maternity (42) Psychiatry(43) Intensive care (12) other1(High Dependency 6);other2(CCU 12); other3(Neonatal ICU 14). Does not mention Gynae (20?) Paeds (42?) specifically].

Total employees: 3723. ~50% nurses, 467/3723 clinical therapist/AHP, 508/3723 admin/mgt, 1% pharmacists

Hospital Strategy:

[wide internal constituency involved] yes.

a wide range of hosp personnel (clinical + others) are involved in approval of QI Policy/Strategy (Approval of aims and mission; Approval of QI policy; Q of care; Safety of care)

Docs + nurses are formally accountable for QI policy

Planning in hospital:

The 3 most important QI priorities are

1. external assessment;
2. patient safety systems;
3. clinical practices guidelines/protocols

Re QI Policy/Strategy:

Documents used in Planning & Control Cycle

Systematically used: Written description of the QI policies and strategies

Sometimes but not systematically used: Q action plan at hosp level; Q action plans; Q manual/handbook; Annual Q report (or section)

The hospital actively subscribes to and seeks inspiration from ISO and IHSAB: holds three ISO certificates, and seeking IHSAB Accreditation.

Results of QI assessments are available to a wide internal constituency, and to a wide external constituency, including academics and some patient groups. Note 'some'.

Staff training is provided in : implementing QI strategies, and Leadership for QI

Many important things are being monitored and discussed at Top Level (Gov. Board), and also with medics (ie appear on agendas of respective two constituencies):
Clinical indicators, complaints handling, patients complaints, 'assessment', incident reporting, internal and external audits, dept. 'production' data, waiting times – elective surg., A&E.

Sickness absenteeism of staff, and turnover of hospital staff are discussed at highest level, but not on agenda of med staff.

External assessment bodies

('yes': pat body; accred inst.; certification inst; govt inspection; (re) assessment by: accred inst; cert inst.)

Internal QI activities

Most Depts - Systematically {Peer review; Adverse events; RM/PatSafety; Monitor views of pats}

- Not Systematically {Internal audit}

Some Depts - Systematically {-} ... Not Systematically

{Int QI; Views of referring professionals}

None: {Regular staff performance reviews}

Pat involvement (indiv/orgs)

Systematically Always {None};

Some of the time - Systematically {none};

- Not Systematically {Patients involved in improvement projects}

No: {Development of criteria/protocols; Design of protocols; Evaluate whether objectives are met; Q committees; Results of pat surveys}

QI Structure:

Identify resp person @ Yes {1+ senior level for QI struct; 1+ pers for Q steering groups; 1+ pers for coordination of QI activities; ... No { External consultants hired}

Identify resp person for:

Yes {Containing hosp infections; Pat safety; Blood transfusions

Antibiotic policy; Prevent decubitus, Health promotion; 1+ for pat falls; 1+ for handwashing }

No: { Internal Budget for QI}

Version 9 of ICD is used

PS. There is an international journal article on the results of MARQuIS pending publication. This will be revisited to reflect the GUH position against Europe-wide experience.

B3. Survey Instruments

Clinical Governance Survey									
Please tick boxes and comment as appropriate									
This form should be completed fully and returned to the designated Officer (name on envelope) by the appointed date.									
Q1	Organisational level:	Managerial	Supervisory	Non-supervisory/ other	Q2	Specialty	Paeds	Obs	Gynae
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q3	Role category:	Medical	Nursing	Allied health professional	Administration / management	Other			
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Person completing this form (this is optional - you may give your name which can be used in follow-up to clarify items raised)						Date			
Please address the following questions from the <u>perspective of your own organisational level & role</u> :									
Q4	Does the Clinical Service have an individual responsible for the management of the following?				Yes	No	Comments		
	a. Clinical Risk Management				<input type="checkbox"/>	<input type="checkbox"/>			
	b. Clinical Audit				<input type="checkbox"/>	<input type="checkbox"/>			
	c. Complaints				<input type="checkbox"/>	<input type="checkbox"/>			
	d. Workforce planning				<input type="checkbox"/>	<input type="checkbox"/>			
	e. Coordination of clinical effectiveness information				<input type="checkbox"/>	<input type="checkbox"/>			
	f. Setting Service quality standards				<input type="checkbox"/>	<input type="checkbox"/>			

From the perspective of your own organisational level & role:	
Q5	Does the Clinical Service use a Hospital incident reporting mechanism to ensure adverse events are identified?
Yes	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>
Rarely	<input type="checkbox"/>
No	<input type="checkbox"/>
Comment	
Q6	Are adverse events openly investigated, lessons learned and changes made?
Yes	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>
Rarely	<input type="checkbox"/>
No	<input type="checkbox"/>
Comment	
Q7(a)	Does the Clinical Service routinely assess clinical risks?
Yes	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>
Rarely	<input type="checkbox"/>
No	<input type="checkbox"/>
Comment	
Q7(b)	Does the Clinical Service routinely put action plans in place to reduce risk to patients?
Yes invariably	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>
Rarely	<input type="checkbox"/>
No	<input type="checkbox"/>
Comment	

From the perspective of your own organisational level & role:

Q8 How often is the quality of clinical record-keeping (medical, nursing, allied health prof, admin/mgt, other) routinely monitored?

- Yes ☐
Sometimes ☐
Rarely ☐
No ☐

Comment

Q9 Does the Clinical Service have a Clinical Audit programme?

- Yes ☐
No ☐

Comment

Q10 If Yes, does the programme involve all relevant clinical staff (medical, nursing, allied health prof, admin/mgt, other)?

- Yes ☐
No ☐

Comment

Q11 Do the results of audits bring about changes to working practices?

- Yes ☐
Sometimes ☐
Rarely ☐
No ☐

Comment

From the perspective of your own organisational level & role:

Q12 Does the Clinical Service routinely hold a meeting to discuss quality issues, i.e. adverse incidents, complaints, clinical audit results, etc.?

- Yes ☐
No ☐

Comment

Q13 If Yes, what is the name of this meeting?

Name of meeting?

Q14 Is this meeting multi-disciplinary, involving all parties including managers?

- Yes ☐
No ☐

Comment

Q15 Does this meeting recommend changes in how services are provided and ensure these happen?

- Yes ☐
Sometimes ☐
Rarely ☐
No ☐

Comment

Q16 Are you discussing quality issues as part of the Clinical Service's business planning process?

- Yes ☐
No ☐

Comment

Q17 Below are a number of statements. *From the perspective of your own organisational level & role*, please rate how strongly you agree with each statement using the scale 1 to 5, where 1 = agree strongly, 5 = disagree strongly

	1	2	3	4	5	Comments
a. Evidence-based practice is supported and applied routinely in everyday practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Workforce planning and development is fully integrated within the service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Development programmes aimed at meeting the needs of the individual health professionals and the clinical service needs are in place and are supported locally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Processes for assuring the quality of clinical care are in place in the service.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Lessons are learned from complaints, and recurrence of similar problems are avoided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Professional performance procedures that help an individual improve their performance are in place and are understood by all staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Clear procedures exist that allow staff to report concerns about a colleague's professional conduct and performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Thank you.

Clinical Governance Climate Questionnaire (CGCQ) : We would like to know what it is like to work in your organisation

This form should be completed fully and returned to the designated Officer (see envelope) by the appointed date.

Q1 Organisational level: Managerial ☐ Supervisory ☐ Non-supervisory/other ☐ Q2 Specialty Paeds ☐ Obs ☐ Gynae ☐

Q3 Role category: Medical ☐ Nursing ☐ Allied health professional ☐ Administration/management ☐ Other ☐ Comment

Person completing this form (this is optional - you may give your name which may be used in follow-up to clarify items raised)

Date

Thinking of the part of the organisation where you work, indicate whether you agree or disagree with each of the following statements. Please rate all the statements on the 5-point scale by circling the number that best represents your opinion.

1= Agree strongly, 2= Agree, 3= Neither, 4= Disagree, 5= Disagree strongly

<i>In the part of the organisation where I work...</i>		<i>(Circle)</i>
1	When things go wrong, there is an automatic assumption that 'someone is to blame'	1 2 3 4 5
2	Good practice ideas are shared with others outside the organisation	1 2 3 4 5
3	Error reporting systems are basically a stick to beat clinicians with	1 2 3 4 5
4	Critical appraisal skills training is available to those who want it	1 2 3 4 5
5	People involved in clinical incidents are made to feel guilty	1 2 3 4 5
6	Career development needs are addressed alongside strategic needs of the service	1 2 3 4 5
7	Staff appraisals are used to punish staff	1 2 3 4 5
8	People have a good knowledge of the skills of their colleagues	1 2 3 4 5
9	We have protected time for quality improvement activity	1 2 3 4 5
11	The emphasis is on how an incident happened, not who made the mistake	1 2 3 4 5

1= Agree strongly, 2= Agree, 3= Neither, 4= Disagree, 5= Disagree strongly

<i>In the part of the organisation where I work...</i>		<i>(Circle)</i>
12	People who make mistakes are supported	1 2 3 4 5
13	We work together across teams to make quality improvements	1 2 3 4 5
14	We collect information on clinical risks	1 2 3 4 5
15	Technical help with evidence based practice is available	1 2 3 4 5
16	When there is an error, we look for failures in systems rather than blame individuals	1 2 3 4 5
17	Appraisal does not identify the real development needs of staff	1 2 3 4 5
18	Long-term planning for quality improvement gets lost in the day-to-day	1 2 3 4 5
19	Colleagues are dishonest with each other	1 2 3 4 5
20	Good practice stays isolated in pockets	1 2 3 4 5
21	Identified clinical risks simply remain unaddressed	1 2 3 4 5
22	Clinical risks are examined in a systematic way	1 2 3 4 5
23	People share practice issues with others in different parts of the organisation	1 2 3 4 5
24	There is no support to deliver service changes	1 2 3 4 5

1= Agree strongly, 2= Agree, 3= Neither, 4= Disagree, 5= Disagree strongly
In the part of the organisation where I work... (Circle)

25	There is no clear vision of what it is that the organisation is trying to achieve	1 2 3 4 5
26	We work in an atmosphere of blame	1 2 3 4 5
27	We don't collect information on the clinical risks that matter most	1 2 3 4 5
28	There is no training available in searching for research evidence	1 2 3 4 5
29	There are lots of quality improvement initiatives, but little real change	1 2 3 4 5
30	There is no common approach to risk management	1 2 3 4 5
31	Teams from different parts of the organisation share their good practice	1 2 3 4 5
32	People devote time to disseminating good practice	1 2 3 4 5
33	The first we know of quality improvements elsewhere in the organisation is when we feel their effects	1 2 3 4 5
34	Service improvements tend to be crisis-led	1 2 3 4 5
35	When a clinical risk is identified, there is always action to address it	1 2 3 4 5
36	Quality improvement is imposed from above rather than built from below	1 2 3 4 5
37	We systematically assess clinical risks	1 2 3 4 5
38	There is no time to get together to share ideas	1 2 3 4 5
39	People share a common vision of service delivery	1 2 3 4 5
40	There is mutual respect for the contributions of all	1 2 3 4 5
41	There is pressure to 'solve' problems quickly rather than take time and do it properly	1 2 3 4 5
42	We don't address the accidents waiting to happen	1 2 3 4 5

1= Agree strongly, 2= Agree, 3= Neither, 4= Disagree, 5= Disagree strongly
In the part of the organisation where I work... (Circle)

43	Clinical risk policies are shared throughout the organisation	1 2 3 4 5
44	Clinical risk information is used routinely to inform decisions	1 2 3 4 5
45	People don't know what their colleagues expect of them	1 2 3 4 5
46	People don't seem to have shared service goals	1 2 3 4 5
47	There is time to reflect on practice	1 2 3 4 5
48	People don't know about good practice taking place in other parts of the organisation	1 2 3 4 5
49	Development needs are regularly assessed	1 2 3 4 5
50	Immediate pressures are always more important than quality improvement	1 2 3 4 5
51	Quality improvement activity is largely a response to external pressure	1 2 3 4 5
52	Risk assessment processes are updated in the light of clinical incidents	1 2 3 4 5
53	Colleagues don't seem to understand each others roles	1 2 3 4 5
54	When something fails, it is used as a learning opportunity	1 2 3 4 5
55	Everyone has the same standing, regardless of professional background	1 2 3 4 5
56	We react to problems, rather than try to prevent them	1 2 3 4 5
57	People are motivated to improve quality	1 2 3 4 5
58	There are few opportunities to use new skills learned as part of development	1 2 3 4 5
59	People are forced into making service changes, rather than encouraged to make them	1 2 3 4 5
60	People are highly motivated to make changes to clinical practice	1 2 3 4 5

survey instrument © Tim Freeman, HSMC University of Birmingham

Items for Six Factors in Clinical Governance Climate Questionnaire (Freeman)

Items and α values for scales

Item -ve

Factor 1: A planned and integrated QI programme ($\alpha = .95$) 21 items

18	✓	Long-term planning for quality improvement gets lost in the day-to-day
20	✓	Good practice stays isolated in pockets
24	✓	There is no support to deliver service changes
25	✓	There is no clear vision of what the organisation is trying to achieve
29	✓	There are lots of quality improvement initiatives, but little change
33	✓	The first we know of quality improvements elsewhere in the organisation is when we feel the effects
34	✓	Service improvements tend to be crisis led
36	✓	Quality improvement is imposed from above rather than built from below
38	✓	There is no time to get together to share ideas
39		People share a common vision of service delivery
41	✓	There is pressure to 'solve' problems quickly rather than take time and do it properly
42	✓	We don't address the accidents waiting to happen
46	✓	People don't seem to have shared service goals
48	✓	People don't know about good practice taking place in other parts of the organisation
50	✓	Immediate pressures are always more important than quality improvement
51	✓	Quality improvement activity is largely a response to external pressure
56	✓	We react to problems, rather than try to prevent them
57		People are motivated to improve quality
58	✓	There are few opportunities to use new skills learned as part of development
59	✓	People are forced into making service changes, rather than encouraged to make them
60		People are highly motivated to make changes to clinical practice

Factor 2: Proactive risk management ($\alpha = .90$) 11 items

14		We collect information on clinical risks
21	✓	Identified risks simply remain unaddressed
22		Clinical risks are examined systematically
27	✓	We don't collect information on the clinical risks that matter most
30	✓	There is no common approach to risk management
35		When a clinical risk is identified, there is action to address it
37		We systematically assess clinical risks
43		Clinical risk policies are shared throughout the organisation
44		Clinical risk information is used routinely to inform decisions
52		Risk assessment processes are updated in the light of clinical incidents
54		When something fails, it is used as a learning opportunity

Factor 3: Climate of blame and punishment ($\alpha = .90$) 9 items

1	✓	When things go wrong there is an automatic assumption that 'someone is to blame'
3	✓	Error reporting systems are basically a stick to beat clinicians with
5	✓	People involved in clinical incidents are made to feel guilty
7	✓	Staff appraisals are used to punish staff
10	✓	It is unsafe to be open and honest with colleagues
11		The emphasis is on how an incident happened not who made the mistake
12		People who make mistakes are supported
16		When there is an error, we look for failure in systems, rather than blame individuals
26	✓	We work in an atmosphere of blame

Items and α values for scales

Factor 4: Working with colleagues ($\alpha = .85$)

6 items

- | | | |
|----|---|---|
| 8 | | People have a good knowledge of the skills of their colleagues |
| 19 | ✓ | Colleagues are dishonest with each other |
| 40 | | There is mutual respect for everyone's contribution |
| 45 | ✓ | People don't know what their colleagues expect of them |
| 53 | ✓ | Colleagues don't seem to understand each other's roles |
| 55 | | Everyone has the same standing, regardless of professional background |

Factor 5: Training and development opportunities ($\alpha = .81$)

8 items

- | | | |
|----|---|---|
| 4 | | Critical appraisal skills training is available to those who want it |
| 6 | | Career development needs are addressed alongside the strategic needs of the service |
| 9 | | We have protected time for quality improvement activity |
| 15 | | Technical help with Evidence Based Practice is available |
| 17 | ✓ | Appraisal does not identify the real development needs of staff |
| 28 | ✓ | There is no training available in searching for research evidence |
| 47 | | There is time to reflect on practice |
| 49 | | Development needs are regularly assessed |

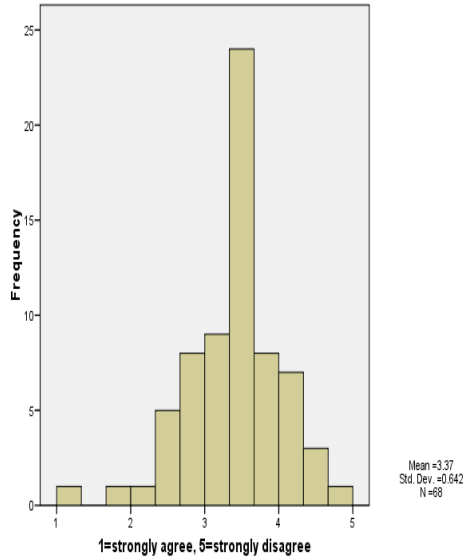
Factor 6: Organisational learning ($\alpha = .87$)

5 items

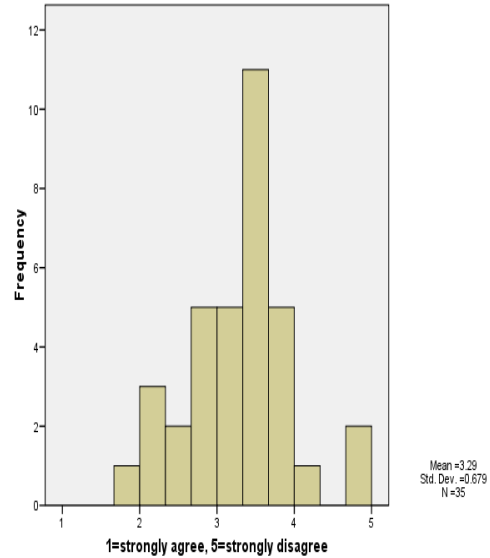
- | | | |
|----|--|---|
| 2 | | Good practice ideas are shared with others outside the organisation |
| 13 | | We work together across teams to make quality improvements |
| 23 | | People share practice issues with others in different parts of the organisation |
| 31 | | Teams from different parts of the organisation share their good practice |
| 32 | | People devote time to disseminating good practice |

B4 (a) Distribution of responses in each CGCQ factor within and between organisation levels

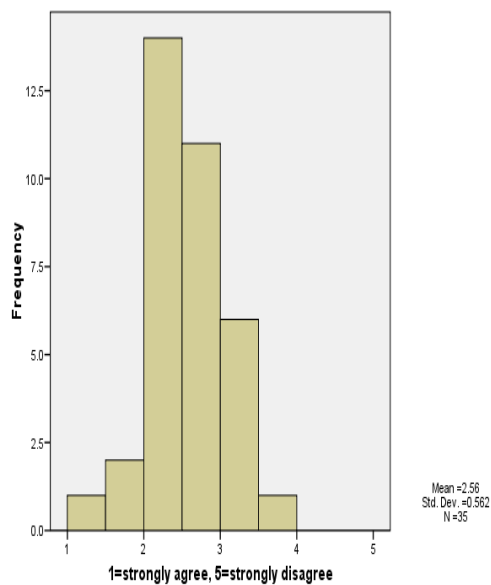
A planned and integrated QI programme exists within this Clinical Directorate-Managers/supervisors



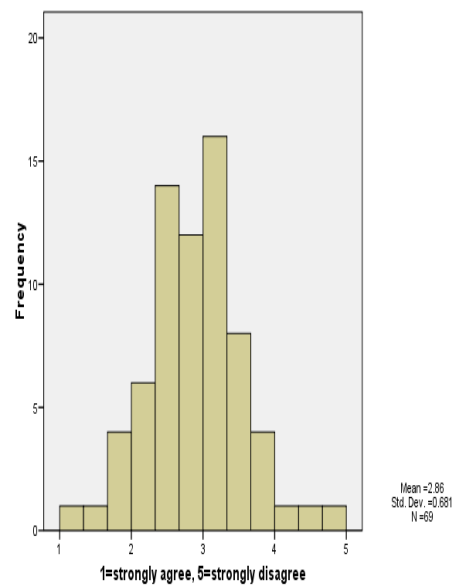
A planned and integrated QI programme exists within this Clinical Directorate-Non supervisory

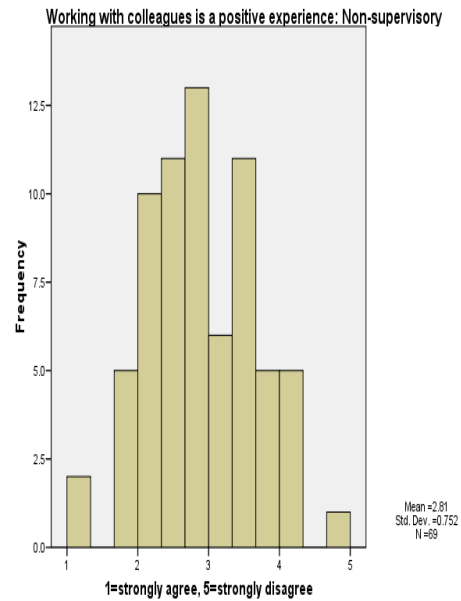
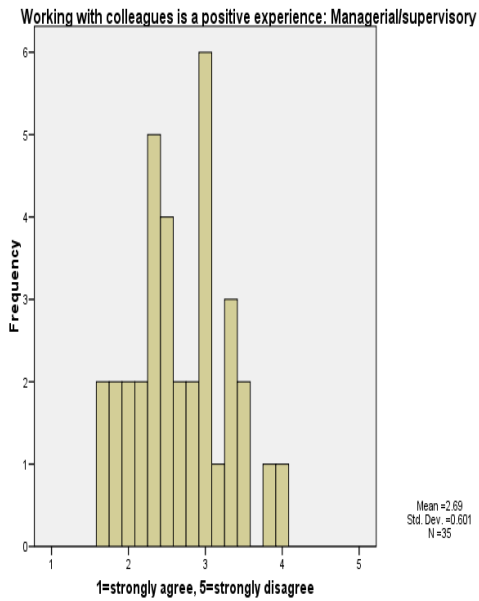
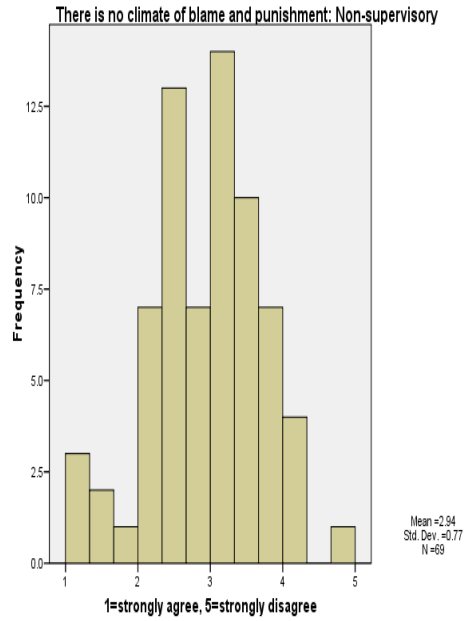
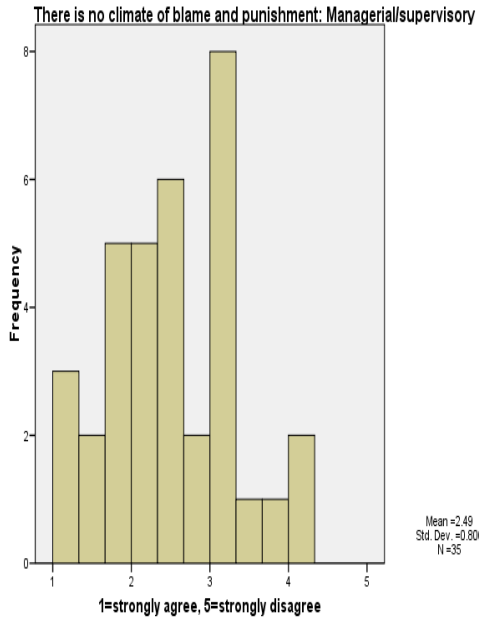


There is pro-active risk management within this Clinical Directorate: Managerial/supervisory

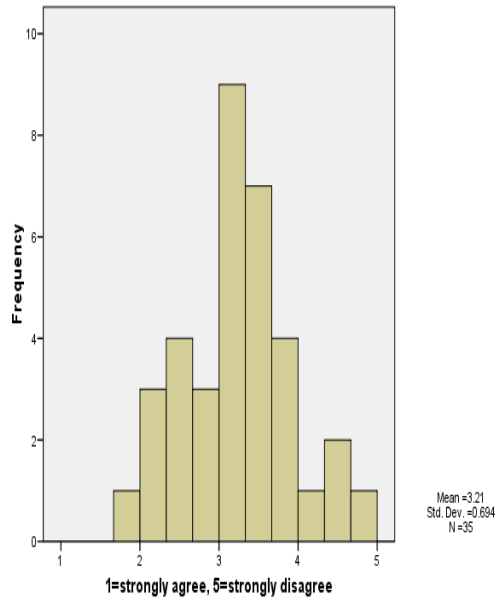


There is pro-active risk management within this Clinical Directorate: Non-supervisory

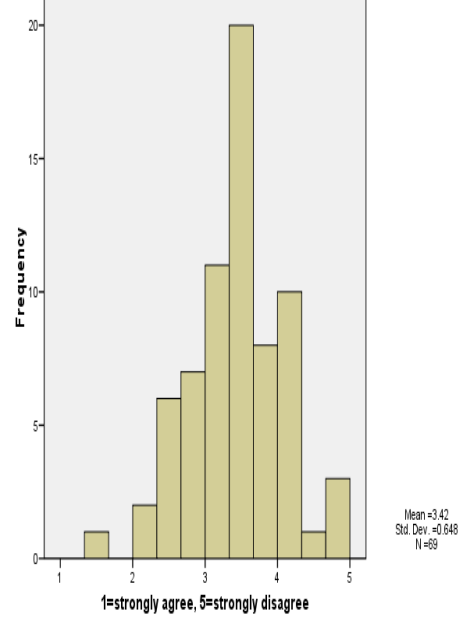




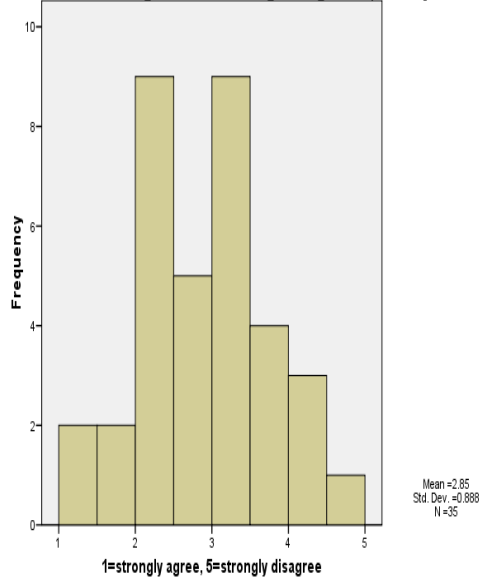
There are good training and development opportunities: Managerial/supervisory



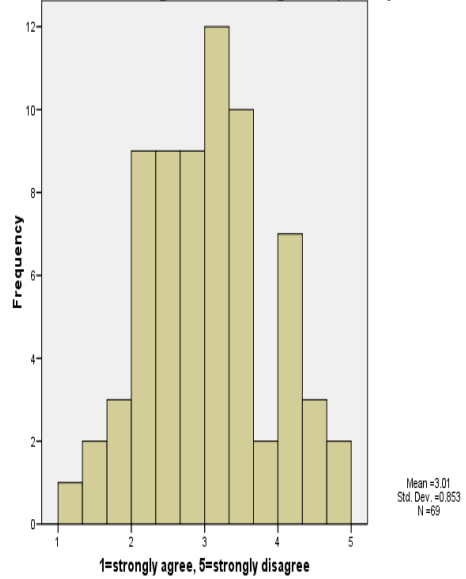
There are good training and development opportunities: Non-supervisory



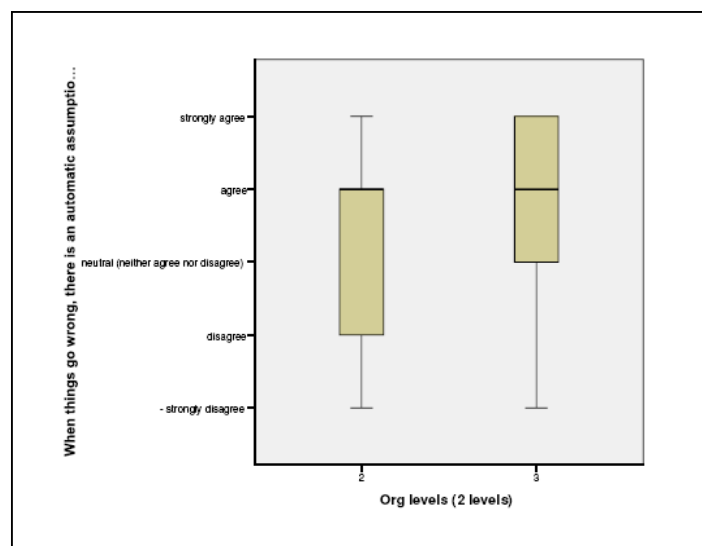
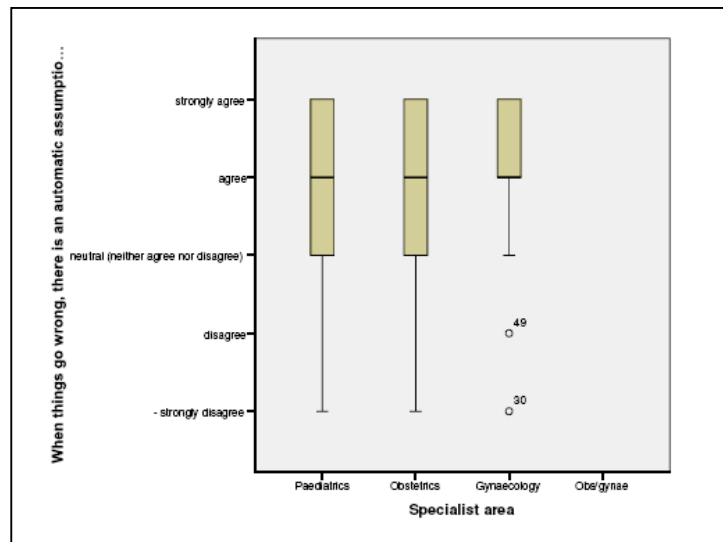
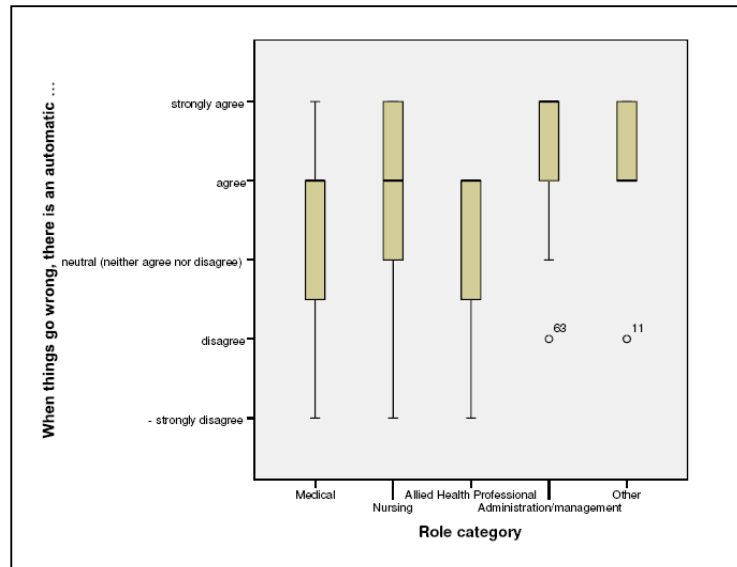
There is organisational learning: Managerial/supervisory



There is organisational learning: Non-supervisory



B4. (b) Samples of distribution box-plots of responses for role categories, specialties and levels



B4. (c) Review of CG Survey and CG Climate Questionnaire based on box-plots

1. Review of CG Survey overall and by strata exceptions

CG Survey Responses						Observations + good resp ~ neutral - poor resp
	Yes	Sometimes	Rarely	No (never)		
CGSQ5	x					all++
CGSQ15	x					Adm:S P:S~ S:Y\W:S
CGSQ6	x	x				N:S Adm&P&O:S/R; I2&3:S
CGSQ7b	x	x				M++ P&O S L2&3: S
CGSQ11	x	x				S/S-Y N+Adm:S;msg:Level
CGSQ7a		x				N&Adm:S/R P:S; I2&3:Y/S
CGSQ8			x	x		M:S/R

CG Survey Responses						+ good resp ~ neutral - poor resp
	Strongly Agree abs	Agree dom	neither neut	Disagree dom	Strongly Disagree abs	
CGSQ17a		x				Ad- G+\P~
CGSQ17c		x				M(+) AHP(-) O(+)
CGSQ17d		x				OG+ S+\Q~
CGSQ17e		x				M~ Adm~ G++ W+
CGSQ17b			x			M++\-
CGSQ17f			x			M(+) P-\G+
CGSQ17g			x			M(+) S(+)

CG Survey Responses						+ good resp ~ neutral - poor resp
	Yes	No	Don't Know			
CGSQ4...						Ad~
CGSQ4a	x					Ad~
CGSQ4b	x					Ad~
CGSQ4c	x					M+/\~
CGSQ9	x					M~
CGSQ4f	x	x				AHP&Adm++, P:N~(OG++)
CGSQ12	x	x				M:Y O:Y S:Y
CGSQ14	x	x				M:Y N:N~ S:Y~W:N~
CGSQ16		x				N+ Adm+ M~ AHP~
CGSQ4d		x	x			all~Obs++G+P~
CGSQ4e		x	x			AHP:N W:~
CGSQ10		x	x			

2. Review of CG Climate Questionnaire with remarks e.g. exceptions (over page)

CG Climate Questionnaire Responses		Strongly Agree		Neutral		Strongly Disagree		Observations			
		abs	dom	neut	dom	abs		+ good resp	~ neutral	- poor resp	
CGCQ_F1 Planned and Integrated QI programme				X		(x)		Specialists- Levels-			
CGCQ39	People share a common vision of service delivery		X	X				M+ N- AHP+ Admin~+ W+ S/W+			
CGCQ57	People are motivated to improve quality		X	X				M/N- S/W+			
CGCQ24	There is no support to deliver service changes			X				AHP~ W- SW= OGP=			
CGCQ25	There is no clear vision of what the organisation is trying to achieve			X				S+ P+			
CGCQ33	The first we know of quality improvement elsewhere in the organisation is when we feel their effects			X				AHP- Admin- S/W- G-			
CGCQ46	People don't have shared service goals			X				AHP+ Admin SW= G+			
CGCQ60	People are highly motivated to make changes to clinical practice			X				AHP+ SW=			
CGCQ20	Good practice stays in isolated pockets		x	X				M+ Admin+ S+ S/W-			
CGCQ29	There are lots of quality improvement initiatives, but no real change		X	X				M- N- AHP+ S/W- OGP-			
CGCQ36	Quality improvement is imposed from above rather than built from below		X	X				M- N- S/W-			
CGCQ41	There is pressure to solve problems quickly rather than take the time to do it properly		X	X				M- N- S/W~+			
CGCQ58	There are few opportunities to use new skills learned as part of development		X	X				S- S/W-			
CGCQ59	People are forced into making service changes rather than encouraged to make them		X	X				M- AHP+ S- S/W-			
CGCQ18	Long-term planning for quality improvement gets lost in the day-to-day		X					M- AHP+ SW= OGP=			
CGCQ34	Service improvements tend to be crisis led		X					SW= G-			
CGCQ38	there is no time to get together to share ideas		X					all agree			
CGCQ42	We don't address the accidents waiting to happen		X					M+ N- AHP- Admin- SW=			
CGCQ48	People don't know about good practice taking place elsewhere in the organisation		X					M- SW= OGP=			
CGCQ50	Immediate pressures are always more important than quality improvement		X					all agree			
CGCQ51	Quality improvement activity is largely a response to external pressure		X					M- AHP+ SW= G-			
CGCQ56	We react to problems rather than try to prevent them		X					M- SW= OGP=			
CGCQ_F2 Proactive RM			(x)	X							
CGCQ14	We collect information on clinical risks		X								
CGCQ43	Clinical risk policies are shared throughout the organisation		X					M- SW= OGP=			
CGCQ52	Risk assessment processes are updated in the light of clinical incidents		X					all agree			
CGCQ54	When something fails it is used as a learning opportunity		X					M- Admin- S/W+ O-			
CGCQ27	We don't collect information on the clinical risks that matter most			X	X			M++ N- AHP- S/W-			
CGCQ21	Identified clinical risks remain unaddressed			X				M++ S+ S/W- OGP=			
CGCQ22	Clinical risks are identified in a systematic way			X				M+ Admin+ S+ OGP=			
CGCQ30	There is no common approach to risk management			X				S+ (S/W-) O+ G-			
CGCQ35	When a clinical risk is identified, there is always action to address it			X				AHP~+ SW= P- G+			
CGCQ37	We systematically assess clinical risks			X				AHP~+ Admin~+ S+ S/W-			
CGCQ44	Clinical risk information is used routinely to inform decisions			X				AHP+ Sup+			
CGCQ_F3 Climate of Blame and Punishment			x	X				M+ W&Ad(-)			
CGCQ3	Error reporting systems are basically a stick to beat clinicians with				X						
CGCQ7	Staff appraisals are used to punish staff				X			SW= OGP= None <~			
CGCQ11	The emphasis is on how an incident happened not who made the mistake		X	X				M/N- S/W- OGP=			
CGCQ26	We work in an atmosphere of blame			X	X			M++ N- S/W-			
CGCQ5	People involved in clinical incidents are made to feel guilty			X				M+ Admin+ S+			
CGCQ12	People who make mistakes are supported			X				M+ SW= OGP=			
CGCQ16	When there is an error, we look for failures in systems rather than blaming the individual			X				S+ OGP=			
CGCQ1	When things go wrong, there is an automatic assumption that 'someone is to blame'		X					Admin~			
CGCQ_F4 Working with Colleagues			X	X							
CGCQ8	People have a good knowledge of the skills of their colleagues		X								
CGCQ19	Colleagues are dishonest with eachother				X			Admin~ SW= OGP=			
CGCQ40	There is mutual respect for the contributions of all		X					AHP~ SW=			
CGCQ45	People don't know what their colleagues expect of them				X			M- Admin- W-			
CGCQ53	Colleagues don't seem to understand each others roles				X			Admin- SW= O~			
CGCQ55	Everyone has the same standing regardless of professional background				X			M- SW= OGP=			
CGCQ_F5 Training and Development Opportunities				(x)	X			M(n) P(n)			
CGCQ4	Critical appraisal skills training is available to those who want it			X				N- W-			
CGCQ6	career development needs are assessed alongside the strategic needs of the service			X							
CGCQ15	Technical help with evidence-based practice is available			X				M+ O+			
CGCQ17	Appraisal does not identify the real development needs of staff			X				AHP- SW= OGP=			
CGCQ28	There is no training available in searching for research evidence		X	X				M-N- AHP- S- S/W-			
CGCQ9	We have protected time for quality improvement activity					X		None >- SW=			
CGCQ47	There is time to reflect on practice					X		M- Admin~ SW= OGP=			
CGCQ49	Development needs are regularly assessed					X		AHP~ Admin~ SW= OGP=			
CGCQ_F6 Org Learning				X				Ad(-)			
CGCQ23	People share practice issues with others in different parts of the organisation		X	X				M+ W+ (S/W+)			
CGCQ2	Good practice ideas are shared with others outside the organisation			X				Adm- SW= OGP=			
CGCQ13	We work together across teams to make quality improvements			X				Admin+ S+ P+			
CGCQ31	Teams from different parts of the organisation share their good practice			X				W- G-			
CGCQ32	People devote time to disseminating good practice			X				SW= G-			
Factors, ranked											
CGCQ_F4 Working with Colleagues			X	X				SW=			
CGCQ_F3 Climate of Blame and Punishment			X		x			M+ AHP+ S+ O+ G- P~+			
CGCQ_F2 Proactive RM			(x)	X				All agree			
CGCQ_F6 Org Learning				X				Admin~ SW= OGP=			
CGCQ_F1 Planned and Integrated QI programme			X		(x)			AHP+ SW= OGP=			
CGCQ_F5 Training and Development Opportunities			(x)	X				M- Admin~ S- P-			

C. Document Analysis

C1. GUH and System Documents Reviewed

Doc title, date, format	Origin (?)
(Accred 1) Accreditation 2007 – Assessing Support Teams 2pp	RM
(Accred 2) A Credit to You – Accreditation interview tips (supporting script) 6pp	anon
Accred 3) Service Planning How Do We Do Our ...(as distributed to W+W&C) 9pp A4 prompts	
(Accred 4) What is accreditation	RM
(Accred 5) Information for accreditation teams	
(Accred 5) Information for accreditation teams 2-sided A4 triptyche (2pp)	
(Accred 6) Evidence of Compliance submitted to the 17 Care Standards 20/08/07. 5pp A4	W&C: GM
(CD 1) Clinical Directorate for Medicine in GUH. Nov 2006 2pp A4	CD project
(CD 2) Clinical Directorate Workshop GUH Friday 14 th September 2007	HR
(CD 4) Obs & Gynae Dept Annual Report 2005	OG Dept
(CD 4) Women's and Children's Clinical Directorate Annual Report 2006	W&C CD
(HOS 1) GUH Strategy for the Future	
(HOS 2) Draft HSE National Service Plan 11 jan 2007 (GUH input)	Hospital
(HOS 3) National Service Plan Format. 35 pp partially complete template with prompts	Hos
(HR 1) GUH Management Structure. 1pp organigram	HR
(HR 2) Women's and Children's Directorate WTE's (Supercedes "Directorate WTE's" for completeness). 5pp	HR
(HR 3) GUH: Executive Management Team Terms Of Reference. 10 th April 2007. 8pp	Hos/ HSE (ref Health Act 2004)
(HR 4) GUH: Hospital Management Team Terms Of Reference. 30 th September 2004. 8pp	Hos
(HR 5) Job Specification for Clinical Director. 11pp A4. undated	HR
(HR 6) Human Resources Dept. GUH Annual Report 2007. 30 th April 2007. 21pp.	HR
(HR 7) Email COH to SdB re Status of Org Development / Change Management Initiatives at GUH 15 th Oct 2007. 2pp.	HR
(HR 9) Training Needs Analysis for GUH. 4pp A4. Undated	HR. JS
(HR 10) Training Needs Analysis for GUH. 4pp A4. Undated	HR. JS
(HR 11) Performance Verification. 2pp A4.	HR
(HR 12) GUH Training Operational Plan for 2007. 127 pp A4.	HR
HR 14 - Job Specification for Business Manager of CD. 9 pages	HR
(HR 15) F/W for functioning of CDs & Hospital Mgt teams in GUH. List of meetings 2pp.	HR
(HR 16) Email COH – SdB re OD Initiatives at GUH	CO'H
(HSE 1) HSE Corporate Plan 2005-2008	HSE Corp
(HSE 2) Transformation Programme 2007-10. 20pp A4.	
(HSE 3) Health Service Reform Programme June 2003. 20pp A4.	DOHC
(ICP1) Overview of Integrated Care Pathways process within Galway University Hospitals. Sept 07. 5pp doc on ICP programme + 3pp list of ICPs installed throughout hospital; + 3pp list of approx volumes per month .	Tina Howard
(ICP 1) Overview of Integrated Care Pathways process within Galway University Hospitals. Sept 07. 5pp doc on ICP programme + 3pp list of ICPs installed throughout hospital; + 3pp list of approx volumes per month	Tina Howard
(ICP 2) UCHG Multiprofessional Integrated Care Pathways for (case) xxx: Case xxx is: I. Paed Tonsillectomy/adenoid/grommet (pilot)	ICP 2 amended Oct 05
(ICP 3) Developing an ICP Draft nov '03. 2-sided A4 triptyche leaflet	HR –ICP
(MARQ 1) MARQuIS Survey	Hos/QMgr
(IS x) Patient Administration Syetem (PAS) Radiology DLaboratory: A Guide for Nursing Staff. Double-sided A4 triptyche. Nov 2006.	IS

(IS 21) [Activity Volumes] Month January 2006	IS
(IS 22) What is HIPE. Undated. 5pp.	IS
(IS 30) GUH Information Systems Work Plan 2008. 16/10/2007. 23pp.	IS. M Molloy
(OG 1) Clinical/Midwifery/Nursing Guidelines.(rev 4; lists 182 guidelines) 8pp 14/05/2007.	OG (ISO)
(OG 2) Safety Policies and Procedures (rev 2; lists 50 documents). 2pp 14/05/2007.	OG (ISO)
(OG 3) Quality Policies and Procedures (rev5; lists 48 documents) 2pp 14/05/2007.	OG (ISO)
(OVW 1) Galway University Hospitals – Powerpoint Presentation	HR. of nov 2006
(QUAL 1) GUH Continuous Quality Improvement Strategy 2006-2008	GUH
(QUAL 2) Quality Improvement Plans (06/06/2007)	
(QUAL 3) (Obs-Gynae) Quality Manual. Multiple volumes.	
(QUAL 4) Quality Bulletin. Issue 2; Oct 2007. 2pp double-sided A4	HR?
(QUAL 5) Quality and IOS 9001 in the Obstetrics and Gynaecology Department, UHG 2pp Information sheet	W&C
(QUAL 6) Terms of Reference for GUH Continuous Quality Improvement Steering Committee. 20th Jan 2006	GUH/HR
(QUAL 7) Clinical Audit Policy (Draft)	GUH
(QUAL 8) Quality of Service Comment Card. Rev 5. 4pp 10x21cm foldout leaflet, ref RM79 Rev. 5. Undated	OG Who?
(RM 1) GUH Healthcare Risk Management Strategy and Policy 2006. 44pp A4	Hos
(RM 2) Untitled risk assessment card. Undated. Double-side A4, colour, laminated.	HSE? Hos?
(RM 3) Women's and Children's Directorate Incidents and risk ratings (end 2007)	RM
(SERV 1) Paediatric Consultant Session Volumes 2004-6 2pp Excel printout	Scheduling dept?
(SERV 2) Schedule of Paediatric Clinics 2pp word doc consisting of tables	Services? Scheduling_dept?
(SERV 3) Schedule of Clinics in Obstetrics and Gynaecology 4pp word doc consisting of tables	Services Scheduling_dept?
(SERV 4) Schedule of Clinics in Obstetrics and Gynaecology 4pp word doc consisting of tables	Services? Scheduling_dept?

C2. Quality Improvement Projects by Intent/ Realisation and Level

		Hospital	CD	Obs	Gynae	Paeds
INTENT	Strategy					entire paediatric unit-plan 6 beds-/Orthopaedic trauma feasibility of neonatal ICU
	Planning			drop-in feeding clinic OPD consulting rooms ultrasound manometry testing outreach midwifery clinic early pregnancy assessment clinic travellers education clinic		plan neonatal P services CF team designated AHP rooms consolation-bereavement area expand MDT- diabetic paeds liaison nurse paeds-primary care extra surgeon OT - chronic conditions outreach nurse nurse - chronically ill expand play area
	Evaluation	audit f/b: documentation auditing system: forms in languages consent forms consent form completion audit g/l's: -consent -wards of court -care pathways		audit discharge process times Audit OPD Consultant wait times audit C-section LOS		
REALISATION	Structure	isolation area- inf control	Risk Register	refurb: OPD interview area	refurbish gynae theatre refurbish gynae wards	refurb- middle section parents' showers in paeds
	Process	S training: customer care; handling complaints g/l: handling abnormal results patient info into many languages g/l: care of the dying g/l:(proto) breaking bad news g/l: handling patients property internet access for research disseminate research results (EBP) health promotion hos/community		systems: link with obs and psychiatry for post natal depression clinical guidelines group G/L: inappropriate diag testing G/L: Cytotec/miscarriage G/L: ethical dilemmas g/l: neonatal feeding & milk fortifier add serial Beta hCG record to chart g/l: early pregnancy testing BetahCG control g/l: ethical dilemmas discharge plans postnatal qres: translation g/l: stem cell policy & service shelved preoperative checklist - TED stockings		ICP: CF prioritising GP referrals neurodevelopmental early intervention team G/L: IV therapy at home equipt maintenance contract expand ICPs in Paeds:CF; diabetes Audio-visual health promo- OPD info pack - baby-friendly hospital g/l: ID children@risk (A&E) discharge summary
	Outcomes					Paeds info for Annual Report

D. Qualitative Analysis

D1 Question Schedule and Prompts: W&CH, CD / GUH Case Study.

Ver: 210108

“Quality improvement in a clinical directorate:
enablers and constraints in performance management”

Time min		
5 (0)	0. Introduction	Us, purpose
5 (05)	1. WHY WAS THE CD MODEL INTRODUCED?	
10 (15)	2. WHAT IS THE ROLE OF THE CD, a. In general? b. In particular	(How they scope it) boundaries (Clinical, SPO) (broadly)
10 (25)	3. HOW IS QI MANAGED? a. what model? b. Why that model (choice, copy) c. What are the results? d. Are these satisfactory?	(Name, description) CRM, CA, Accred, ISO, CQI Hosp QC Benchmarking ... Whose, CIS (why, what standard, expectation, realisation)
10 (35)	4. TO WHAT DO YOU ATTRIBUTE THESE RESULTS? a. What circumstances enabled? b. What circumstances constrained	- leadership and influences – (internal and external) - ownership, ... capability / capacity ... attitude, motivation, - context – internal, external - resources, capacity, technology, IS - autonomy
10 (45)	5. WHAT NEEDS TO CHANGE? a. What b. Why c. How	
5 (55- 60)	6. Review	Sweeping up loose items

D2. Template A

The Clinical Directorate

1. Formative Influences:

(i) External

- Evidence that CD works- visits to other Hospitals in Ireland and UK (L1)
- Accepted worldwide as best way (L2 c)
- DoHC and Network Management require it (L2 a)

(ii) Internal Influences

- Inadequacy of previous arrangements

- HoDs had no formal recognition in the management structure (res. & acc) and were controlled by the Medical Board (L1 c)
- Clinical Co-ordinators were not part of the management structure; role was very wooly! (L1 d)
- A centralised decision structure lacked clinical input and accountability for spending (L1 d)

- Hospital Management Objective

- GM initiative (as DN) with Divisional Nurse Management anticipated CD (L1 c)
- HR interest and support for CD (L2 b)
- Integration of 2 Hospitals/ Sites through clinicians in management (L1 g)
- A participative decision making structure (L1 d) and accountability by engaging people (L1 d)

- Consultation Process

- Sell idea to H. Management Team (L1 g)
- Accept in 5yr Strategic Plan (L1 b,g)
- Medical Board support subject to (3) majority representation on EMT (L1 d) and Consultants' agreement (L1 c)
- Nurse Management could see the benefits (L1 j)
- Took a lot of time to get full commitment (L1 a), some clinicians were reluctant and did not buy-in (L1 a)- it was a power thing for them (L1 d)

2. Perceived Purpose:

- Why Involve Clinicians in Management

- Close to patient (L1 a)
- Spend most (L1 j)
- Have lack CD self managed (L30 c)
- Have a big input as to how the service runs (L30 a)
- Increase awareness of service issues (L1 k)
- N.B.-Fears in the past that involvement in management would compromise role in patient care (L1 d)

-Integrated/Participative Management

- A governance structure that is more accountable (L1 g) more cohesive in Service Planning (L1 g)
- Manage own budget and staff (L30 a)
- Manage budget, more efficiency and improve patient service (L40) manage own budget and staff (L3 p, b)
- More efficient management, improve partnership and co-operation (L2 a)
- (Influence)- direction of Hospital (L3 pa)
- Manage a smaller area with separate/own budget, improve Service and Quality of Care (L4 p)

3. CD Scope/ Logics

- Historic (General)

- A long history of specialties working together (L1 b)
- Problem of 2 Hospitals/Sites e.g. Radiology (L1 g)
- Size (Med & Surg), controversy 2v4 Dirs (L1 d); too large and unwieldy (L1 b); too big and diverse (L1 a), piggy-backed, power transferred (L1 d)

- Boundaries

- Very important for education, training and feedback (L1 a)
- Very difficult as still accountable to GM and Professional Bodies (L1 a)
- Advised to keep no. CDs Small and manageable (L1d)

- W&C (Internal) Historic

- Always attached (OG/ Pds) (L1 d)
- Strong links through neonatal (L1 g)
- Paeds & OG fell together (L2 b)
- Historically connected mother & baby (L4)
- Very close links Mat & Paeds (L3 pc)
- We were doing it except we didn't have the title (L2 b)

External Influence

- Model came from Management Steering Group (visit to UK) (L3 Pb). London example impressed (L1 d)

Other

- Don't know (L3 oa)
- Arbitrary decision- same links were needed (L3 Pa)
- Artificial to have (W&C) but neo and perinatal links to outcomes is important (L3 Pq)

4. CD Role & Current Status

- Terms of Reference

- Defined at a high level (L1 a)
- Empower to manage within constraints (L1 a)
- None (L2 c) (L 30 C)
- Don't know (L3 Pb)

- Purpose

- (i) Manage Resources

- Have financial control (in infancy, I thought my financial role could come with CD) (L3 Pb)
- Have responsibility for resources and have ownership (L30 c)
- Nurse Management involved if budget/ costs (L2 C)

(ii) Plan, Implement, Report

- Do Service Plan and Monthly Reports (L1 b)
- Implement Service Plan and be accountable to EMT (L1 d)
- Plan, share problems and communicate with Paeds (L3 OC)
- Report 3 month to EMT, 2 week HMT (L1 g)

(iii) Improve the Service

- Manage the area and provide best standards of practice and development (L3 Pc)
- Improve service and facilities, discuss service needs, staffing, near misses (L4 P)

(iv) People/ Incident Management (C. Dir)

- Manage, co-ordinate, liaise with colleagues (L1 d)
- People management at every level- the hardest thing! (L2 a)
- Deal with everyone's problems, every clinical incident (L2 a)

5. CD Team & Reporting Relationships

- Director

- Report MDT led by Dir, report to EMT (L1 j)
- C. Dir to- GM, report to EMT (L1 d) (interacts with colleagues/peers- positive attitude to own!)

- Team Members

Accountable to GM (L1 g)

- CD decisions to HMT to EMT (L1 d)
- All levels ultimately answerable to C Dir (L2 a)

- Team Reports

- C. Dir, AND, AHP (L2 C)
- 4CD members (L3 Pc)
- CD, BM, NM, AHP (L3 Oa, c)
- CD, NM, BM (L4 O)
- BM to DGM (broken line? Change role)
- BM to CD to GM (L1 j)
- Admin to BM to C Dir (L1 a)
- NM to DN/ CD (L1 j)
- NM to DN (Profl.) and CD (Opl (L1 b)
- ADN has close working relationship with DN (?blur and need to let go (L1 b)
- NM dual link (CD & DN); position is not clear (L2 C)
- Nurse to NM to DN (L4 P)

6. CD Status

- General

- Only now assigning control mechanisms on finance, others being decided by HSE (L1 C)

- Lines of Accountability

- Consultants not answerable to C Dir, no control over clinical practice (L2 a)
- Most members run an independent system e.g. NM to DN (L2 a)
- Authority devolved with a very strong focus on Q in teams (L1 a)
- Book stops at C Dir level (L2 a)
- All levels ultimately accountable through Dir (L2 a)

- Unity of CD

- 2 Depts merged (L1 a)
- Exist as 2 Depts- Paeds meeting input to CD meetings (L4 P)
- Paeds didn't have Paed rep- 2yrs and no Paed agenda relative to OG (L3 Pb)
- Paeds in CD came later (L3 Oa)

-Issues

- C Dir Role- start again, you can't do 2 jobs (RMS as buffer between med & mgt in past) (L3 Pd)
- Unions don't recognise CD structure and won't meet C Dir (L2 b)

Leadership

- Style

- By consensus- have a good team- democratic, open decisions made for the good of the unit (L2 a)
- B. very persistent, supportive and motivated, very aware of appropriate pathways. Prof very persistent if he decides (last Accred visit and Gyn. Th) (L3 Oa)
- U. really good communicator, very strong work ethic, quality orientated, can see the big picture and future opportunities (L3 Oa)
- Limited interaction with them- but they are very service and quality orientated (L3 Oa)

- Limitations

- Everyone is trying so hard to lead but gone are the days when you can direct and dictate- that's the dilemma- a very frustrating issue (L1 b)
- What unions will allow! (L3 Oa)
- ? Leadership role- we have to go through so many layers of people- anything local must send to CQI for approval (L2 C)

7. Clinical Leadership

- Positive

- Good, but a certain amount of subjectivity depending on the speciality- different with W&C (L1 b)

- L. trickles down- comes from clinical leadership and on ward. You can feel it on the (ground) floor (L4 O)
 - Definitely there (W&C) (L1 d)
 - Good at CD and Ward level- not language in use (well managed) (L2 b)
-
- Some leadership on the ground. Overall there is a minority of Leaders. Unfortunately, the culture of this organisation does not really have any arena for good leadership. Sometimes TM might not be good leaders (L3 OC)
 - For years, no clinical leadership- it was confined to higher management of H & clinicians who made decisions on various services (L1 K)

8. CD Characteristics

- Very much unity there (M&S different) (L2 b)
- Very strong for meetings, feedback- takes a lot of effort (L2 C)
- Good teamwork (L1 d)
- Not much cross-disciplinary working. MDT re policy and guidelines (medical mainly) (L2 e)

CD/ W&C

Performance Management

1. IT Roles and Input to IS:

(i) National IT: (1)

- Supposed to be a strategy, need to shake up, don't appear to understand needs at H level (1 c)

(ii) Local (IT): (1²) + ¹)

- Had to build own independent system (1 c)
- Willing to engage and improve hospital's performance; not sure if they understand the information required (1 h)
- ICT (role) in Radiotherapy, Laboratory and trying to establish role in M&S (1 h)

2. Information Systems W&C:

(i) GUH- Fin & HR (1²)

- Really quite poor- working with CDs we rely on people to give information (1 a)
- Have finance tools (1 c)

(ii) GUH- HIPE: (1², 2², 3.OP)

- Activity data through- (1 b)
- No seasonal changes, can't tell trends (3 Ob)
- Discharge summary done personally by me (3 Pd)
- Big deficit in coding; backlog 23k cases (1 h)
- Paeds info (2 b)
- Need more information for different groups (2 c)

(iii) CIS- General: (1³)

- Poor in the past and still restricted in what we can do (1 c)
- Needs improvement (1 k)
- Very good in ICU, Radiotherapy- need evaluation (1 d)

CIS- W&C: (1⁽⁴⁾ + (2) + ¹, 2, 3.OP²)

- Very good in OG (works with IT and dramatically improved in their understanding (1 c)
- Good in W&C (2 b); OG use (3 Oa, c)
- Satisfactory in OG- not in Paeds (1 b)
- None in Paeds (1, a h) manual (1 c) (3 Pd)
- Paeds very low in technology- have some internal measures (1 g) – don't have IT so can't look up the type of stats (3 Pa)
- Upgrade- could become national (1 h)
- +10years- (needs) upgrade (1 c)
 - unique in producing information regularly (1 c)
- Not part of reporting structure (1 c)

(iv) Medical Records: (1²)+¹)

- No EPR (1 a)
- A problem in the management of medical records- A Task Force assigned in weak areas (1 k)
- Started e-discharge summary (1 k)

(v) STARS Web: (2, 3.O)

- For Incident Report and dissemination to all Depts (2 c)
- In use (3 Oc)

EuroKing, KQ: (3.O)

- In use- Q Pulse initiated (3 Oa)

Eurocat: (3.P)

- Congenital Abnormalities Centre (3 Pd)

(vi) Clinical Information: (2, 3.O²P)

- Crucial! My clinical data was most helpful to me in analysing the issues and trying to ascertain where the priorities lay. A non-clinical person would be easily led up the garden path (2 a)
- I don't do anything (data)- I have a diagnostic index for my outpatients (3 Pd)
- Perinatal Mortality reviewed monthly (3 Oa)
- Rudimentary (3 Oa)

(vii) Performance- PIs, Standards, Targets

- PIs: (1²)+ ²)

- We have some but they are difficult to implement and I look at my own level of performance (if WTEs over) (1 a)
- Plan to improve; participate in the national project (1 h)
- Try to agree some key PIs in some specialities e.g. W&C (1 a)
- CD PIs in SP (1 g)

- Standards: (1)

- In W&C- they set themselves action plans, measures and outcomes and outputs (1 d)

-Activity Targets: (1²)

- Devolved- to each speciality (1 a)
- W&C have a reasonable handle on activity and performance (1 k)

-DASHBOARD etc: (1²)

- Dashboard being evolved (1 h)
- Things we didn't measure before: (1h)
 - efficiency ratios
 - Benchmark (ATHs)
 - NHO- info/waiting times

(viii) Performance- Status CD/GUH (1²+², 2)

- Performance management is under-developed here (GUH) (1 a)
- Have to have self regulation- more investment is required in control systems (1 a)
- No self-regulation, basically monitor themselves (1 k)
- Performance is monitored by EMT- monthly report, meet quarterly (1 d)
- Don't really measure performance for results (2 c)

CD Performance (W&C)

(i) Positive (1², 2⁽⁴⁾, 4.O²)

- Broke ice in getting going philosophically as a combined Directorate (1 a)
- Very innovative, patient focused, very cohesive, dynamic (1 b)
- Works very well- brought an awareness and unity to influence others (2 b)
- Good teamwork (2 b)
- Very good teamwork; work well together, good relationship with staff on the ground (2 c)
- Achieved general agreement on Directorate Model (2 a)
- Managers have more control of reporting (4 O)
- Service improvement in weak areas (2b)
- Service improved from the patients point of view in Gynae (4 O)
- Service activity up but no extra res. (2 b)

(ii) Improve!: (4.O².P³)

- Haven't seen a huge change- got emails but don't read them (4 O)
- Not aware in daily work (4 P)
- Don't see Dir.- majority not know there is CD (4 P)
- Has not affected my life (4 O)
- Presence of CD is not tangible (4 P)

- Communications: (3.O³.P²)

- Don't hear from meetings (4 O)
- A lot more information from BM when audit is coming up (4 O)
- Never acknowledged, never know it (performance); no staff appraisal or individual performance review (4 O)
- Never see the likes of us brought to a meeting (4 P)
- Need better communication from Director down- not often communicated (4 P)

-General: (4.O²)

- OG - a Consultant based service (4 O)
 - Midwifery-led antenatal outreach clinic was well monitored (4 O)

Quality Management

1. Model in Use (1, 2², 2.O².P²)

- Not really a model (1 a)
- No specific model adopted- a combination of different ways of managing quality (3 Pa)
- Not familiar with Hospital model (3 Oa)
- No formal scheme looking into Q Culture (2 b)
- A bit traditional (ISO, Accred, Clinical Committees, Labour Ward Forum, Perinatal Forum, feedback) (2 a)
- Q talk tends to be about improving service and not Q (3 Oa)
- Don't know- standards are my own personal experience; 30 years in total control of my patients until that changed! (3 Pd)

2. Strategy and Planning (1³, 2)

- Q in the Mission Statement and Partnership Process (1 j)
- QI plan sets targets- a slow process (1 b)
- GM message- Q is in everything- have to set standards in policy and procedure (1 k)
- Excellent RM strategy- CRM based on it. (2 e)

3. Q Agenda & Structure

3.1 – Agenda (1, 2⁽²⁾, 3.OP)

- Q very much on the agenda (1 g)
- Q not on formal CD agenda (2 b)
- Do not put Q on agenda deliberately (2 b)
- Not seen Q as a recurring theme on agenda (3 c)
- Agenda of CD is, to an extent, to develop guidelines and procedures through our Paeds Committee to Directorate. (3 Pa)

3.2 - Structure (1⁽³⁾+³, 3.O².P)

CQI

- CQI Steering Committee get issues from CD (1 c)
- CDs nominate to Committee; 3 Sub Committees (Clinical Audit, ICP, Policy/ Procedure/ Guidelines (1 j)
- Steering Group looks at multi-disciplinary policies and procedures (1 b)
- CQI & RM Cttees; Chair links to Med. Board (1 j)
- Very much clinician-led; protocols and guidelines are very high on agenda. 2 years ago it would not have happened (1 j)
- (CQI Cttee) has strength but it can only pick small areas at a time (1 k)
- QI Team in OG only- meets monthly (3 Oc)
- QI is the responsibility of BM (3 Oc)
- C Dir. has a certain responsibility for managing Q (3 Pa)

CRM (1, 2⁽²⁾, 3.P⁽²⁾+²)

- W&C rep. on CRM Cttee (2 e)

- Very active RM Group with Senior Nurse- they are good to work on policy and procedures. They produce the critical incident report (1 g)
- CRM- needs a dedicated person like C. Dir- because of a lack of ownership it comes back to us for follow up (2 e)
- CD has input to CR & Patient Safety (3 Pa)
- Dir. provides overview of CRs and addresses them (3 Pa)
- Risk Advisor Reports incidents and relays them back to staff meetings (3 Pb)
- I don't get reports- Sr. looks after that (3 Pd)

Reviews: (1, 2(2), 3.OP)

- RM meets GM weekly and discusses issues (1 j)
- Monthly Q meeting (2 b)
- CRM Reports reviewed weekly at CD meeting (2 b)
- Weekly review of CR forms in Labour Ward- very serious cases reviewed immediately and feed into Risk Advisors (3 Oa)
- Review all CR forms at CD weekly (3 Pa)

Complaints (1)

- DN responsible for – (1 b)

Labour Ward Forum (3.O)

- All disciplines talk issues e.g. risk and recurring topics (3 Oa)

Clinical Audit (3(2)+1)

- Reports presented at monthly meetings (3 C)
- Caesarean Sn. Audit monthly with national and international comparison (3 a)
- Perinatal Mortality Review monthly (3 a)

ISO

Positive (1², 2², 3.0(2) + (2)+1P)

- Started in OG, lent itself to Q- not my first choice (1 a)
- Use ISO standard and compliance (3 Oc)
- OG far ahead in programme- advanced ISO- a very good tool for managing Q (2 b)
- OG more advanced than Paeds (need some buy-in) (1 g). Accreditation Group will decide re Paeds/ ISO (3 Oc)
- Kept ISO Cert since 1996 (3 Oc)
- Accreditation Group will decide re Paeds/ ISO (3 Oc)
- Good policy and procedures- audit gives more coherence (2 c). Comprehensive policy and procedure statements (3 Oa)
- Documented process, the system of updating is very good, a lot of information is managed very well and is available. Quite a Q System the way it is managed (3 Oa)
- Internal Q Audit use ISO standards for compliance and correction (3 Pc)
- ISO facilitated transfer to Accreditation- more advanced than paed (need same buy-in) (1g)

Improve: (3O.P²)

- Should roll-out to Paeds (3 Pb)
- Don't use ISO (3 Pa)
- We will go with Q Pulse (documentation) to improve communication (3 Oc)

Feedback: (2.3O)

- From Patient Focus Groups (3 c)
- Do a lot of Focus Groups with parents (2 c)

Accreditation/ EPB (3.P², 4P)

- Accreditation standards, ICP and CP (3 Pc)
- Accreditation and EBP (4 P)
- EBP- everybody updates themselves on practice (3 Pb)

Performance:

(i) **Q. Management- General**

Positive (3P⁽²⁾, 4P)

- H. Steering Group- a huge impact since set up (3 Pd)
- Is very good (4 P)
- Q is very good- nurse standards are extremely high (3 Pd)

Improve: (1⁽²⁾+4, 2)

- Not sure if people see Q as part of everyday work (1 k)
- Q is not embedded in day to day business (1 h)
- QI Team in OG only, none at CD level (3 Oa)

(ii) **Accreditation**

Positive (1⁽²⁾+4, 2)

- Very positive around team working- it has put Q on everyone's agenda in the Hospital- involving patients and more- the journey of getting there is CQI (1 a)
- Increased development and training and multi-disciplinary working (1 d)
- Process has been hugely beneficial (1 k)
- Transmits Q- a self assessment process- flagging up deficits in policy and guidelines (1j)
- An overwhelming process- we cannot achieve some of the things- it highlighted our good points and deficiencies (3 Pa)
- GM-DC first trained as assessor- they embraced it from its inception- a unifying experience that promoted multi-disciplinary working- people met people they never met before (1 b)
- Very much pre-occupied with Accreditation. Audit (2 a)
- Committed to Accreditation process- a catalyst for very positive improvement (1 a)

Improve (1, 3.O².P⁽²⁾+(²))

Accreditation:

- No impact on practice (3 Pd)

- Don't know enough to buy into it- not hugely impressed- site visit didn't engage clinicians or women- but, good to be aiming for something (3 Oa)

Clinical Audit:

- Purely medical clinical audit- not multi-disciplinary (1 k)
- Not enough Clinical Audit Projects. W&C are one of the better ones but not enough from Paeds (poor relation) (1 j)
- Conduct random audits (1 b)
- Internal audits aspire to Q- selected on a need to know basis e.g. Breast Screening (1 g)
- Ireland is very poor in auditing outcomes (3 Pa)
- Clinical Audit is not prominent- mainly medical- nursing (audit) is in its infancy (3 Ob)
- Don't audit as such. (3 Pd)

W&C:

- 9/10 for listening to patients in OG (3 Oc)
- Principally a very strong team with good senior staff (1 b)
- Contributed to Q focus; put patient at centre, always looking at something new to improve care (1 b)
- OG came a long way in Quality and Risk
 - Better than most (2 e)
 - Very effective- satisfaction rate 98% from comment cards- patient discharge complaints process (2 b)
- Made inroads to Quality. CD is doing well (3 Pa)

Annual Report (2)

- W&C Annual Report: all put up front publicly e.g. high risk incidents, perinatal death (no external comparison) (2 a)

Benchmark (2⁽²⁾+¹, 3)

- No formal Benchmark (OG) (2 b c)
- Paeds feed into Vermont/Oxford database (2 b)
- Vermont/Oxford Q Control database on Q and Outcomes- see our performance against the rest of the world (3 Pa)

Constraints

External to GUH

1. HSE:

(i) Management (1²)

- Problem with HSE- there are so many so called managers who are not managing- they are more advocates for their staff instead of taking management decisions (1 b)
- Management development is weak
 - HSE do not train managers well.
 - If you stick it out long enough you will get G.V or VI- but you are not developed as managers (1 c)

(ii) Control (1⁽²⁾+⁽²⁾, 3.O⁽²⁾, P⁽²⁾+¹)

- Style is top-down (1 h)
- HSE don't want any change- they are dictating from the top and you are caught in the middle (1 d)
- Too big- initiatives that GM can't do because it has to be a HSE decision (3 Oc)
- A centralised power in Dublin- it removed power from local admins- it is very hard for the GM and network manager to make any significant changes without going back to HSE. I think it is a hugely retrograde step- you can criticize our local managers for not being able to make changes- the problem is they can't make these changes (1 k)
- Role of GM is changed- a lot of flexibility is gone from the system- it can be very frustrating- arrangements in the past may have been too loose- HSE at this stage is really managed by resources and unions
 - There are inefficiencies and layers of management (1 h)
- Targets in the Service Plan are dictated by the HSE (1 j)
- GM & HR have been undermined to a great extent HSE control is a great constraint (1 d)
- Motivation is being eaten because we are being constrained with the environment of HSE- morale is not high (3 Oa)
- Impact of embargo- , fearful that temporary people on sick leave will not be replaced (3 Oa)
- CD idea is good but HSE has so much control and restriction that nothing can be achieved to anyone's satisfaction (3 Pc)
- (HSE says) Tighten belt! But there is not much discussion about change (3 Pa)
- The key issue with the HSE is it is hugely micro-managing the system because they view huge inefficiencies in how hospitals are run. It is very hard for management to make decisions because their hands are tied from above (3 Pa)

2. HIQA (1)

- Standards are putting (more) pressure (1 g)

Internal GUH

1. Control & Resources: CD (1⁽³⁾ + ¹, 2⁽²⁾ + ³, 3.OP⁽²⁾, 4.OP²)

- We want to develop new governance structures but we are under-resourced (1 g)
- No budget yet- don't know cost- finance budget never devolved to me (1 b)
- At the moment our whole lives are hingeing around two things- WTEs and bed capacity (1 b)
- Don't know level of vacancies and costs (1 b)
- Finance has not set any budgets for the Directorate, no maintenance budget (2 c), we still have to go through the same system (2 a)
- No budget, someone in Finance is looking into it (2 e)
- Responsibility, but no budget (2 c)
- Don't have full control of budget and staffing (embargo) (2 b)
- No responsibility for spending here yet, no financial accountability, no petty cash, no freedom to purchase (3 Oa)
- No budget, no one in Dir can actually dictate or have a say in staffing levels (3 Pd)
- No budget- nothing happening- skeptical! Start again (3 Pd)
- No budget or control over staff numbers (4 O)
- Still feeding into Finance & HR (4 P)
- No control over staff no's (4 P)

2. Ownership (1⁽²⁾ +²)

- CDs have yet to take full ownership and grasp of management. A number are still grasping the role, responsibility and authority (1 d)
- We want to develop new governance structures but we are under-resourced (1 g)
- GM asked by HSE for report- we send it to CD who meet and consider it- they comeback and will argue about risk (1 d)
- When the chips are down its back to me. I empower others, but yet I am expected to have the answer- nobody likes making unsavoury decisions (I am happy for Directors to take full responsibility for WTEs and decisions for the service- that's not happening! It is a real concern) (1 b)

3. Authority (2⁽²⁾ +¹, 3.O⁽²⁾.P⁽²⁾+¹, 4 O)

- Is very limited. I expected more authority and autonomy but I don't have it (2 c)
- WE submit a Business Plan but don't have any influence to implement what we want. GM decides priorities and we still feed into EMT who ultimately make the decisions for us (2 b)
- Still back to GM! (3 Pb)
- The 'responsibility' devolved from hospital management. is limited (3 Oa)
- No scope over HR, budget or service changes- with anything that might influence (3 Oa)
- See problems and potential solutions but don't have scope to follow through (3 Oa)
- Limited control over what we can do, no control over manpower (3 Pa)
- Things not devolved down to level of Directorates (3 Pa)

- No discussion-it is more direction! (4 O)
- People need to start letting go (2 c)

4. Structure (1⁽³⁾ + (2) +⁽²⁾ +², 2, 3.O⁽²⁾ +¹.P⁽²⁾, 4.O)

- Not a huge buy in from all stakeholders e.g. nurses entrenched, Medical Board & AHPs positive (1 k)
- Don't know if Nursing has taken it on (1 j)
- There is resistance on the ground to a clinician in charge as a Dir. (1 k)
- More layers of management! (2 c)
- Another layer (BM to GM) (3 Oa) to go through (3 Oa, c)
- CD just another layer of communication between clinical staff and management (3 Oa)
- More difficult to get decisions, another layer to go through and no budget allocated (3 Pb)
- Now, a lot of layers in the system. Can't get anyone to make a final decision- can get a bit with policy but not with service (3 Pb)
- Too many Nurse Managers- the Commission on Nursing made a mistake (4 O)
- BM role needs to be looked at (1 j)
- BM expected to be all things to all people (1 c)
- NM-DN reporting is an operational blur (1 h)
- Nurse line in particular still goes from ADN to DN, then Manager (1 k)
- Maybe we have not let go- still have a close working relationship with all ADNs and a supporting role (1 b)
- Concerns about Paeds, would they be frozen out in the new order (1 c)

Capability (2⁽²⁾ +²)

- Consultant (Mgt) Training- a management course of one week's duration at the end. No preparation here- 3 to 4 Sns. (2 c) since, but no formal education or training in management (2 a)
- We didn't get much training (2 b)
- No training- we hold our own meetings and identify our training needs (2 C)

Change?

Control (14, 2³) +¹, 3.O(2) +¹.P, 4P)

- Would like full involvement in the budget- give us autonomy and WTEs, be more supportive, give power and information (1 g)
- Need more flexibility- a lot of flexibility is gone and there are a lot of inefficiencies (1 h) lift embargo! (1 b)
- Devolve the budget, reward people for change. All the CDs say that if they implement change in their own areas, unless they see a reward, it is very hard to convince people of the benefit- where fiscal benefits follow- as the following year you are penalised as the budget is based on last years performance- so you are penalised! (1 k)
- Own budget and responsibility for spend (2 b)
- Need budget devolution, otherwise, it is a pseudo-Directorate (2 c)
- HMT allowing unions not to acknowledge the Directorate- still have to go to EMT with things we want to do (2 c)
- When we get a budget, we will make more strides (3 Oc)
- Need more devolved budget if they want us to manage our own affairs (3 Oe)
- These things need to be in our hands (3 Oc)
- Need adequate staffing levels, not Crisis Management, to perform my role as a manager (3 Pc)
- Need own budget, staff recruitment and HR (4 P)
- Need more information for decision making, more autonomy (2 c)

Structure (2, 3P)

- Need a national formalisation of the role of CD and it needs to be given substance (2 c)
- Combine the 2 Units and gain efficiencies in the system (3 Pd)

Clinical Governance (1², 2², 3.O)

- Some degree of TQM next- CQI would be better (1 a)
- Get involved! (2 c)
- More proactive reporting of incidents- clinical risk and unreported incidents are a worry- wasn't to see the Risk Register up and running- prioritise risk in the organisation (2 e)
- Hopefully the CD will push Clinical Leadership- it is trying to- (3 Oc)
- Clinicians have to buy-in to Q data for Q planning (1 h)

Management (3.O, 4P)

- Get all managers trained; the only person who knows what's happening on the general side is- , there is a different culture there (3 Oc)
- Need better communications from Dir. down- not often communicated (4 P)
- Hope to see more input (4 P)

Facilities/ Staffing (4P³)

- Improve the buildings (too distant from H) and staffing levels (4 P)
- More beds required, staff levels low (4 P)
- Hope to see more improvements with CD (4 P)

D3. Template A1 (Basic Framework and Refs)

1. Formative Influences:

(i) External (1, 2²) - Hospital & CD Management

(ii) Internal Influences – Hospital Management

- Inadequacy of previous arrangements (1³)

- Hospital Management Objective (1⁽²⁾ + ³)

- Consultation Process (1⁽²⁾ + (2) + (2) + ³)

2. Perceived Purpose:

- Why Involve Clinicians in Management (14, 3.0²) – Hospital & Dept O.

- Integrated/Participative Management (1², 2, 3.OP², 4.OP) – All levels

3. CD Scope/ Logic (1⁽²⁾ + (2) + ²)

- Historic (General)

- Boundaries (1⁽²⁾ + ¹)

- W&C (Internal) Historic (1², 2⁽²⁾, 3P, 4P)

External Influence (1, 3P)

Other (3.O P²)

4. CD Role

- Terms of Reference (1⁽²⁾, 2, 3.OP) – Hospital CD & Dept

- Functions

(ii) Manage Resources (3.OP, 2) – CD and Depts

(ii) Plan, Implement, Report (1³, 3.0) – Hospital & Dept O.

(iii) Improve the Service (3P, 4P) – Dept/Ward P.

(v) People/ Incident Management (C. Dir) (1, 2⁽²⁾) – Hospital & CD

5. CD Team & Reporting Relationships

- Director (1²) – Hospital

- Team Members (1², 2) – Hospital CD

- Team Reports (1³, 2⁽²⁾, 3.0², 4.OP) - All levels

6. CD Status

- General (1) - Hospital

- Lines of Accountability (1, 2⁽⁴⁾) - Hospital CD

- Unity of CD (1, 3.OP, 4P) - Hospital Dept, Ward P.

- Issues (2,3P) - CD, Dept P.

Leadership

- Style (2, 3O ⁽³⁾) – CD, Dept O

- Limitations (1, 2, 3.O) – Hospital CD, Dept. O.

7. Clinical Leadership

- Positive (1², 2, 3.O, 4.O) – All Levels (3/4.O)

- Improve (1, 3.O) – Hospital Dept. O.

8. CD Characteristics (1,2³) – Hospital CD

CD/ W&C

Performance Management

1. IT Roles and Input to IS:

(i) National IT: (1) - Hospital

(ii) Local (IT): (1⁽²⁾+ ¹) – Hospital

2. Information Systems W&C:

(i) GUH- Fin & HR (1²) - Hospital

(iii) GUH- HIPE: (1², 2², 3.OP) – Hospital, CD, Depts

(iii) CIS- General: (1³) - Hospital

CIS- W&C: (1⁽⁴⁾ + (2)+ ¹, 2, 3.OP²) – Hospital, CD, Depts

(iv) Medical Records: (1⁽²⁾+¹) -Hospital

(v) STARS Web: (2, 3.O) – CD, Dept. O

EuroKing, Q: (3.O) – Dept O

Eurocat: (3.P) – Dept P

3. Information Application

(i) Clinical Information: (2, 3.O²P) – CD Depts

(ii) Performance- PIs, Standards, Targets – Hospital
- PIs: (1⁽²⁾+ ²)

- Standards: (1)

-Activity Targets: (1²)

-DASHBOARD etc: (1²)

Performance

GUH

(i) Status GUH (1⁽²⁾+², 2) – Hospital, CD

CD W&C

(ii) Positive (1², 2⁽⁴⁾, 4.O²) - Hospital, CD, Ward O

(iii) Improve!: (4.O².P³) - Ward

- Communications: (4.O³.P²) - Depts

- General: (4.O²) – Ward O

Quality Management

1. Model in Use (1, 2², 3.O².P²) – Hospital CD, Depts

2. Strategy and Planning (1³, 2) - Hospital CD

3. Q Agenda

3.1 – Agenda (1, 2⁽²⁾, 3.OP) - Hospital CD, Depts

4. Structure- Activities (1⁽³⁾+³, 3.O².P) - Hospital, Depts

CRM (1, 2⁽²⁾, 3.P⁽²⁾+²) - Hospital CD, Dept P

Reviews: (1, 2⁽²⁾, 3.OP) - Hospital CD, Depts

Complaints (1) - Hospital

Labour Ward Forum (3.O) – Dept O

Clinical Audit (3⁽²⁾+¹) - Dept

ISO

Positive (1², 2², 3.O⁽²⁾ + (2)+¹P) - Hospital CD, Depts O/P

Improve: (3.O.P²) - Depts

Feedback: (2.3.O) - CD, Dept O

Accreditation/ EPB (3.P², 4P) – Dept/Ward P

Performance:

(i) Accreditation

Positive (1⁽²⁾+⁴, 2) – Hospital, CD

Improve (1, 3.O².P⁽²⁾+⁽²⁾) – Hospital, Depts

(ii) Quality Performance

GUH

Positive (3P⁽²⁾, 4P) – Dept/ Ward P

Improve: (1⁽²⁾+⁴, 2) – Hospital/ Ward

W&C:

Benchmark (2⁽³⁾+¹, 3) - CD & Dept

Constraints

External to GUH

1. HSE:

(i) Management (1²) - Hospital

(ii) Control (1⁽²⁾+⁽²⁾, 3.O⁽²⁾, P⁽²⁾+¹) – Hospital Depts

2. HIQA (1) - Hospital

Internal GUH

1. Control & Resources: CD (1⁽³⁾ + ¹, 2⁽²⁾ + ³, 3.OP⁽²⁾, 4.OP²) – All levels

2. Ownership (1⁽²⁾ +²) – Hospital

3. Authority (2⁽²⁾ +¹, 3.O⁽²⁾.P⁽²⁾+¹, 4 O) – CD, Depts Ward O

4. Structure (1⁽³⁾ + (2) +⁽²⁾ +², 2, 3.O⁽²⁾ +¹.P⁽²⁾, 4.O) – All levels

Capability (2⁽²⁾ +²) – CD

Change?

Control (14, 2⁽³⁾ +¹, 3.O⁽²⁾ +¹.P, 4P) – Hospital CD, Depts, Ward P

Structure (2, 3P) – CD Dept P

Clinical Governance (1², 2², 3.O) – Hospital CD, Dept O

Management (3.O, 4P) – Dept O, Ward P

Facilities/ Staffing (4P³) – Ward P

D4. Template A2 (Narrative)

The level perspectives cover a range of topics i.e. the Clinical Directorate Performance Management, Quality Management, Constraints and Change expectations.

The CD is perceived in terms of formative influences, perceived purpose and role, scope, functions and reporting relationships, control and leadership style.

Management is presented in terms of Performance and Quality Management. The former notes the role of IT and its relationship with W & C Directorate, the use of PIs and progress with the CD Model. There isn't a hospital model as such but the Quality Structures outline various tools and mechanisms with regard to various elements of its clinical governance and overview of Quality Management.

The Constraints are dominated by external and internal control issues. These are concerns about HSE management capacity and central control in the HSE.

The limited budgetary devolution and control in GUH affects ownership and the status of the CD structure from various perspectives. There are expectations of change re structure, management control, and clinical governance, facilities and staffing.

1. Clinical Directorate: (Structure)

Formative Influences: (Hospital & CD Mgt)

There are attributions of external and internal influences. The former refer to national and international evidence that CDs work (1, 2) and that the system wants them (2). The latter refer to inadequate arrangements in the past e.g. Heads of Department and Clinical Co-ordinators who did not have formal authority and accountability in a centralised structure without clinician input (1). Hospital Management initiated the clinicians in management project. It is intended to facilitate hospital-wide integration and enable participative decision structures and accountability (1, 2).

Perceived purpose, scope & role

Clinicians are close to the patient and have direct service influence. Their input to and awareness of service issues and the high level of their spend point to the need for 'self managed' CDs (1). In the past, such involvement would have caused them fear of compromising their patients' care (1, 3). A more accountable and cohesive governance structure is envisaged (1). CDs will have local ownership of performance management with a budget, staff control and management of service quality and its improvement (2,3P.4OP).

CD Scope/Logic

CD boundaries reflect historical relationships, service rationalisation, goals and the scope and scale of units (1). These have implication for CD learning and manageability. The accountability lines still go to the GM and Professional Bodies (1). The combination of OG & Paeds in W & C is based on historical links and needs! (1, 2, 3P, 4). “We were doing it except we didn’t have the title” (2b). The model was endorsed having observed a UK site (1.3P). Some see the decision as arbitrary but recognise the need for some link (3.OP). The CD terms of reference is defined at a senior level and is intended to empower so as “to manage within constraints” (1a). However, people are unaware of the terms of ref. at departmental level (3.OP).

T6 CGs

Workforce planning and development is fully integrated within the service?

CD Functions and reporting relationships

CD functions include resource management (3.OP) and service planning (1). That extends to sharing problems and communications with Paeds (3.O), improving service standards and performance and in dealing with needs and issues (3P.4P). The Director reports to the EMT through the GM (also interacts positively with peers) (1). Team members are accountable to the Director (2) with decisions referred to HMT and EMT (1) reporting to those levels (2). 4.OP). There are dual role-relationship issues regarding the DGM and DN.

Control.

At present, control is located at hospital and HSE levels (1). In addition, Consultant independence (2) is a challenge to the authority and accountability of the Clinical Director (1, 2). Unification is slow even if there is good teamwork (1). The CD is described as 2 Depts merged (1) ‘exist as two Depts’ (4P) and the gradual engagement of Paeds in the CD is noted. (3.OP). There are problems regarding recognition by unions (2) and professional bodies (3P). CD management assert that there is unity, good meetings & feedback although cross-disciplinary working is mainly for medical policy and guidelines (2).

T1 CGCQ

Working with colleagues?

Leadership style

The leadership style is democratic and team based (2). Two members are described as very persistent, another is a good communicator who has a very strong work ethic, is quality orientated and sees the big picture. They are all very service and quality orientated (3.O). There are barriers to leadership e.g. traditional directive style (1) unions (3.O) and layers of management (2).

Clinical leadership is either “definitely there”, “good with some subjectivity” (1) “trickles down” or “comes from the ward”, “you can feel it on the ground floor” (2, 3.O, 4.O). But, “unfortunately, the culture of this organisation does not really have any arena for good leadership” (3.O). “For years it was confined to higher management of the hospital” (1).

T¹ CGCQ

Absence of unjust blame and punishment?

2. Performance Management

IT and IS (Structure)

Inadequacies at National IT level necessitated local initiative and engagement with some IT role distribution to hospital units (1). There are references to STARS, EuroKing, Q Pulse (3) and an evolving Dashboard (1). There are reported local deficiencies e.g. Finance, HR, Medical Records, HIPE limitations and restricted CIS with some exceptions (1, 2, 3.OP).

In W&C, CIS works with IT and is quite good (1, 2, 3.O). It needs an upgrade but could become the national standard (1). Paeds are very low in technology (1) with information consequences (3P).

Clinical information is crucial! , “my clinical data was most helpful to me in analysing the issues and trying to ascertain where the priorities lay” (2a) but some clinicians have limited use of data (3P).

Performance (SPD)

There are some Performance Indicators agreed for some specialities. It is planned to develop them through a national project and the service plans. However, ... “they are difficult to implement when I look at my own level of performance (WTEs)” (1a).

Activity targets are devolved. W&C set action plans, measures and outcomes and have a reasonable handle on their activity and performance (1).

Performance Management is under-developed and under-invested so that real self-regulation is limited. EMT monitors CD performance (1) but there is a view they “don’t really measure for results” (2c).

W&C is progressing. It is (the CD Model) “getting going philosophically as a combined Directorate” (1a), and there is “general agreement on the Directorate Model” (2a). The CD characteristics are “good”, “very good teamwork”, “unity”, “good relationship with staff” (2) and very innovative, cohesive and patient focused (1b). There are service improvements (2, 4.O) and increased activity (2). There is more to be done as there is a low level of CD awareness and impact at the front line (4.OP). Communications need to improve “need better communication from Director down...” (4P).

T¹ CGCQ

- Training and Development opportunities
- Organisational Learning

T₄ CGS

- Professional Performance procedures that help an individual improve are in place and understood by all staff
- Clear procedures exist that allow staff to report concerns about colleagues’ professional conduct and performance.

3. Quality Management

Q Model T¹

There is no formal Q Model in use. There is a combination of Q approaches and fora (1.2.3OP). One perspective is that “Quality talk tends to be about improving service and not quality” (3.Oa) and for another, “standards are my own personal experience...” (3P).

There are strategies and plans for Q (1, 2). “The GM message is that Q is in everything” (1k). While some say that Q does not go on the CD agenda (2b, 3Oc) others disagree or associate it with the development of guidelines and procedures (1, 3P).

Q Structures (Structure)

The Q structures include the *CQI Steering Committee*. The CDs nominate reps and submit issues to it. It looks at multi-disciplinary policies and procedures (1). The Chair links to the Medical Board. It is very clinical-led (2 years ago it would not have happened (1j) but it can only pick small areas at a time (1k).

In W&C, the Director and BM have responsibility for managing Q. The QI team meets monthly (3.OP).

The *Clinical Risk Management Committee* has a W&C Rep (2) and input to CR and Patient Safety (3P). The Clinical Director provides an overview of risks and addresses them (3P). There is a very active risk group who produce policy, procedure and reports (1). RM needs a dedicated person otherwise it comes back for follow up (2).

RM reviews take place weekly with the GM (1j) and monthly Q meetings (2b) , at CD meetings (2b, 3Pa) and in the Labour Ward (or more frequently) (3.Oa).

At the Labour Ward Forum all disciplines` discuss issues e.g. risk and recurring topics (3.0). The monthly *Clinical Audit (CA)* Reports and Reviews include Caesarean Sections and Perinatal Mortality (3). There is a need for improvement in CA. Hospital Management observes that there is insufficient CA; at best it is selective and primarily medical (1). Departmental Management confirm that it is mainly medical and some “don’t audit as such” (3P). In any case “Ireland is very poor in auditing outcomes (3P).

ISO in OG has very positive recognition in the management of Q since 1996 (1, 2, 3O). It facilitated the transfer to Accreditation (1). The Accreditation Group will decide about if for Paeds (3.OP). The benefits from ISO are in the systematic management of Q (3Oa), comprehensive good policy and procedures (2.3O) and internal Q Audit standards for compliance and correction (3P).

Accreditation’s positive dimensions relate to multi-disciplinary teamwork, development, training and putting Q on everyone’s agenda (1). Its self-assessment process flags up deficits in policy and guidelines (1) and highlighted good points and

deficiencies (3P). There is a commitment to (1) and pre-occupation with Accreditation (2).

Alternative perspectives on Accreditation indicate that, “it has no impact on practice” (3P) “not hugely impressed- site visit didn’t engage clinicians or women...” (3.O); “an overwhelming process...” (3P).

Q Management Overview

Regarding Q Management in general, the CQI Steering Group has made a huge impact. It is very good (3P, 4P). W&C is doing well (3.O). The CD has a very strong team (1). It is very effective and better than most (2). Nursing standards are extremely high (Paeds) (3P). OG score high on listening to patients. It has made inroads to Q (3P) and has come a long way in Q & R and contributed to a Q patient-centred focus (1).

Benchmarking is primarily connected with Paeds. The Vermont/ Oxford database enables international comparison on Q and Outcomes in neonatal care (2.3).

CGCQ

T¹

- Presence of a planned and integrated QI Framework?
- Proactive Risk Management?

(Structure)

CGS

T²

- Responsible? - CRM, CA, Complaints
- (Structure) - Workforce planning
- Effectiveness
- Setting S.Q. standards

Existence CA Prog?

- (Structure) - Involve all relevant staff?
- Meet routinely to discuss Q
- (Outcome) - Do the results of audits bring about changes to working practices?
- (Structure) - Q meeting multi-disciplinary?
- Q issues part of Business Planning Process?

T₅ (Process) - Does this meeting recommend changes, how services are provided and ensure these happen?

T₆ - Evidence-based practice is supported and applied routinely in everyday practice? (Structure/Process)

T₅

- Are adverse events openly investigated and lessons learned and changes made? (Process/Outcome)
- Lessons learned from complaints and the recurrence of similar problems avoided? (Outcome)

- Does the C.S. routinely put action plans in place to reduce risk to patients? (Structure/ Intervention)

CGS

T³

- Does Clinical Service use a Hospital Incident Report mechanism? (Process)
- Does C.S. routinely assess Clinical Risk? (Process)

T₄

- Processes for assuring quality of clinical care in place in the service

T₅

- How often is the quality of record keeping monitored? (Process)

4. Constraints

External

HSE Management & Control

There are major concerns about management capacity and the extent of central control in the HSE.

Many managers are nominal and are more staff advocates the decision makers. Being time served rather than being trained and developed is a management selection criterion (1). There are inefficiencies and layers of management (1). The top-down, centralised style has removed local power and flexibility and limited GM decision authority (1.3O). “HSE is hugely micro-managing the system” (3P). Service Plan targets are dictated by the HSE (1). Paradoxically, “the HSE don’t want any change” (1) and local managers can’t make changes (1). The consequences are that it is “managed by resources and unions (1k), local management are undermined (1), “motivation is being eaten because we are constrained with the environment of the HSE (3.O). Because of the embargo there are fears of non-replacement (3.O).

HIQA

Their standards create more pressures (1)

Internal

Limited Budgetary Devolution and Control (Structure)

There is an emerging scepticism (3P). No budget and no control over staff numbers! This resonates through all levels of GUH/CD (1, 2, 3OP, 4OP). For example, Finance never devolved the budget” (1) it has not yet set any budgets for the Directorate (2); someone in Finance is looking into it! (2). Regarding staffing issues, they don’t know the level of vacancies or the costs or control over staff numbers (4.OP). They want to develop new governance structures but are under-resourced (1). “At the moment our whole lives are hingeing around two things- WTEs and bed capacity” (1).

Ownership and Control (Structure)

CDs have yet to take full ownership and management. “I empower others, but yet I am expected to have the answer- nobody likes making unsavoury decisions” (1b). A corollary is the consequence of hospital management having to engage CD input in preparing reports for the HSE and deal with issues raised (1).

In contrast, CD and Departmental management say that CD Authority and responsibility is very limited (2.3.O). “There is limited control over what we can do” (3Pa). There is no scope to solve problems, change services or anything that might influence (3.O). The GM decides priorities and the EMT ultimately make the decisions (2). Things are not devolved down to the level of Directorates- it is still back to GM (3P). It is more direction than discussion (4.O) so people need to start letting go (2).

There are complaints about the status of the new CD structure from all levels (1, 2, 3, 4). There is not a huge buy-in from all stakeholders (1). There is resistance on the ground to a clinician in charge and it is not clear if nursing has taken it on (1). They still have a close working relationship with all ADNs (1). The Nurse line is dual (CD & DN) so that there is an operational blur (1). The BM who is expected to be all things to all people but the role needs to be reviewed (1). Another shared view is that there are more layers of management! (2) another layer to go through/ between clinical staff and management (3.O); a lot of layers in the system and more difficult to get decisions (3P). There are also too many nurse managers (4.O). There is little evidence of training for the Clinical Director or BM (2).

5. Change

Change expectations relate to structure, management, control, clinical governance and facilities/staffing.

Budget and Control (Structure)

There is a significant call for more localised control from all levels (1, 2, 3.OP, 4P). This focuses primarily on the budget eg full involvement, autonomy, more support and power, flexibility and the need to reward people for change (1); responsibility for spend. The call is for devolution otherwise it is a pseudo-Directorate with HMT allowing unions not to acknowledge the Directorate (2). “When we get a budget we will make more strides, (3.Oc), manage our own affairs; these things need to be in our hands (3.O). The required combination is to own the budget, have staff control (4P) and more information and autonomy (1, 2).

Clinical Governance & Leadership (Structure)

Clinical Governance (1, 2, 3.O) needs more clinician buy-in (1), clinical leadership (3.O), more general involvement (2) and pro-active reporting of incidents (2).

Capability & Capacity (Structure)

The role of Clinical Director needs to be formalised nationally and given substance (3). In addition the 2 units have to be combined to gain efficiencies (3). Management training (3.O) and better communications from Director down is necessary with opportunities for more input (4P). Facilities, staffing levels and bed capacity have also to be improved (4P).

D5. Template B (themes, with data fragments)

1. Leadership Style:

- (i) HSE: The style is top-down (1h), they don't want any change, they are dictating from the top and you are caught in the middle (1d). A centralised power in Dublin...says 'tighten belt'! (1k) but there is not much discussion about change (3Pa), no discussion, its more direction (4 O)
- (ii) GUH Past: A centralised decision structure that lacked clinical input and accountability for spending (1d). HoDs were controlled by the Medical Board (1C) and the role of Clinical Coordinators was very woolly (1d). Neither was part of the management structure (1d).
- (iii) GUH Present/Future: A participative, accountable decision making structure (1d); a more accountable & cohesive governance structure (1g).
- (iv) CD: Very innovative, patient focused, very cohesive, dynamic (1b), consensus, democratic, open decisions made for the good of the unit (2a), very service and quality orientated (3 Oc), A good team, A&B very persistent (3Oa), B supportive and motivated, very aware of appropriate pathways (3Oa), C a really good communicator, very strong work ethic, quality orientated, can see the big picture and future opportunities (3 Oa).
- (v) *Clinical Leadership*: (a) Good, but a certain amount of subjectivity depending on the specialty (different with W&C) (1b). Good at CD and ward level (2b). It trickles down, comes from clinical leadership and on the ward; you can feel it on the floor (4 O), definitely there (1d).

Limitations : Some leadership on the ground (3 Oa). Overall there is a minority of leaders.

Unfortunately the culture of this organisation does not really have any arena for good leadership. Sometimes TM might not be good leaders (3 Oc)

Leadership is not the language in use (well managed!)(2b). For years there was no clinical leadership, leadership was confined to higher management of the hospital and clinicians who made decisions on various services (1k). Everyone is trying so hard to lead, but, gone are the days when you can direct and dictate, that's the dilemma, a very frustrating issue (1b). What Unions will allow! (3 Oa).

Clinicians in Management:

Involvement:

The rationale arises from being close to patients (1a) and they spend most (1j). They have a huge input as to how the service runs (3 Oa) and can increase awareness of service issues (1k). The intention is to have each CD self managed (3 Oc). In the past they feared that their involvement could compromise their role in patient care (1d). The external evidence is that CDs work (1d) and is accepted worldwide as the best way (2c). The DoHC and Network Management require it (2a). It is a GM initiative (1c) with HR interest and support (2b). It is also motivated by the need to integrate the 2 hospital sites (1g).

Process:

It took a lot of time to get full commitment (1a) and sell the idea to HMT (1g). Nurse Management could see the benefits (1g). The Medical Board support was subject to majority representation on EMT (1d) and the consultants` agreement (1c). Some clinicians were reluctant and did not buy-in (1a). It was a power thing for them (1d). CIM was accepted in the 5 Year Strategic Plan (1b, g).

HSE Management: The Problem is that many so called managers are not managing, they are more advocates for their staff instead of taking management decisions (1b); management development is weak, HSE do not train managers well, if you stick it out long enough you will get a Gr IV or V but you are not developed as managers (1c).

GUH Management:

HSE is too big with the result that there are initiatives that GM can` t do because it has to be a HSE decision (2Oc).

HSE removed power from local administrators. It is very hard for the GM and Network Manager to make any specific changes without going back tom HSE. I think it is a hugely retrograde step. You can criticise our local managers for not being able to make changes. The problem is that they can` t make these changes (1k). The role of GM is changed; a lot of flexibility is gone from the system. It can be very frustrating. Arrangements in the past may have been too loose. HSE at this stage is really managed by resources and unions (1k). GM and HR have been undermined to a great extent. HSE control is a great constraint (1d).

Motivation is being eaten because we are being constrained with the environment of the HSE. Morale is not high (3 Oa). The key issue with the HSE is it is hugely micro-managing the system because they view huge inefficiencies in how hospitals are run. It is very hard for management to make decisions because their hands are tied from above (3Pa).

CD Management:

i) CD Role:

No/don` t know terms of reference (2c, 3 Oc, 3Pb), defined at a high level (1a), empower to manage within constraints (1a).

Reports: Clinical Director to EMT (1d, j), to GM (1d); to HMT to EMT (1d).

CD team, all levels ultimately answerable to Clinical Dir (2a, 1j), accountable to GM (1g) Duality- BM to CD/GM(1j), NM to DN/CD (1j), Nm to DN (profl) and CD

(oprl), AND has close working relationship with DN (?blur , need to let go) (1b), NM dual link (CD/DN), position is not clear 92c), nurse to NM to DN (4P)

(ii) Management Functions:

Resources:

Own budget & staff (3 Oa, 3 Pb, 4 O, 4P); responsibility for resources and have ownership (3 Oc); have financial control (3Pb).

Plan, implement and report:

Do Service Plan and monthly reports (1b), implement Service Plan and be accountable to EMT (1d), plan, share problems and communicate with Paeds (3 Oc). Report (3 month) to EMT, (2 week) HMT, discuss service needs and staffing (4P)

Improve the Services:

Provide best standards of practice and development (3Pc); improve service and quality of care and facilities, discuss near misses (4P), improve patient service (4O), more efficiency (2a, 4c).

People Management:

Manage, coordinate & liaise with colleagues (1d), people management at every level, it is the hardest thing! (2a); deal with everyone's problems.

Incident Management:

Discuss near misses (4P), deal with every clinical incident (2a).

CD Progress:

Positive: (i) Structure: Broke ice in getting going philosophically as a combined Directorate (1a),

achieved general agreement on Directorate model (2a), managers have more control of reporting (4 O), (Med Board and AHPs positive).

(ii) Authority: Devolved with a very strong focus on quality in teams (1a), book stops at Clinical Director level (2a), all levels ultimately accountable through the Clin Dir (2a)

(ii) Good teamwork (1d, 2a,b), very good team, works well together, good relationship with staff on the ground (2c). Principally a very strong team with good senior staff (1b)

(iii) CD Unity: Works very well, it brought an awareness and unity to influence others (2b) Very much (M&S different) (2b), very strong for meetings, feedback takes a lot of effort (2c).

Service: Improvement in weak areas (2b), improvement from the patient's point of view in Gyn (4 O).

Activity up but no extra resources (2b). A Consultant-based service, midwifery-led antenatal outreach clinic was well monitored (4 O)

CD – Negative:

Awareness: Not aware in daily work (4 O), haven't seen a huge

change, it has not affected my life (4O), majority don't see, don't know there is a CD, presence of CD is not tangible (4P)

Buy-in: Not a huge buy-in from all stakeholders eg nurses entrenched. There is resistance on the ground to a clinician in charge as a Director (1k). Some have yet to take full ownership and grasp of management. A number are still grasping the role, responsibility and authority (1d). When the chips are down its back to me. I empower others but yet, I am expected to have the answers, nobody likes making unsavoury decisions (1b), maybe we have to let go, still have a close working relationship with all ADNs and a supportive role (1b)

Recognition:

(i) *Roles:* Clinical Director role must start again, you can't do two jobs (in the past the RMS was a buffer between medics and management) (3Pd), Unions don't recognise the CD structure and won't meet the Clinical Dir. (2b). Consultants are not answerable to the Clin Dir (2a), no control over clinical practice (2a), most members run an independent system eg NM to DN (2a)

Team: BM, needs to be looked at (1j), expected to be all things to all people (1c) NM to DN reporting is an operational blur (1h), the nurse link in particular still goes from ADN to DN then manager (1k).

(ii) *Layers of Management:* More! (2c), another layer to go through (BM to GM) (3Oa, c), CD is just another layer of communication between clinical staff and management (3Oa), more difficult to get decisions, another layer to go through and no budget allocated (3Pb), now a lot of layers in the system, cant get anyone to make a final decision...can get a bit with policy but not with service (3Pb). We have to go through so many layers of people, anything local we must send to CQI for approval (2c).

(iii) *Communications:* don't hear from meetings (4 O), never acknowledged, never know it (performance), no staff appraisal or individual performance review (4 O), never see the likes of us brought to a meeting (4P), need better communication from Director down, not often communicated (4P), A lot more info from BM when audit is coming up (4 O).

(iv) *CD Unity:* Two Depts merged (1a), they exist as two Depts (4P). Didn't have Paeds rep for 2 years, no Paeds agenda relative to OG (3Pb), Paeds in CD came later (3Oa), concerns about Paeds , would they be frozen out in the new order? (1c).

(v) *Teamwork:* Not much multidisciplinary working, re policy and guidelines, medical mainly (2a)

Authority:

Very limited, I expected more authority and autonomy but I don't have it(2c). We submit a Business plan but don't have any influence to implement what we want. GM decides priorities and we still feed into EMT who ultimately make the decisions for us (2b), Still back to Gm (3Pb). The responsibility devolved from hospital management is limited (3Oc).

No scope over HR, Budget or Service changes....with anything that might influence (3Oa. See problems and potential solutions but don't have scope to follow through (3Oa).

Limited control over what we can do; no control over manpower (3Pc). Things not devolved down to level of directorates (3Pa)

Resource Management:

We want to develop new governance structures but we are under-resourced (1g)

I thought financial control would come with CD (3Pb), only now assigning control mechanisms on finance, others being decided by HSE (1c)

No budget---don't know cost, financial budget never devolved to me (1b), Finance has not set any budgets for the Directorate (2c), still have to go through the same system (2a), someone in finance looking into it (2a), responsibility but no budget (2c), still feeding into Finance and HR (4P), no responsibility for spending, no financial accountability, no petty cash, no freedom to purchase (3Oa), nothing happening, sceptical! Start again! (3Pd)

Staff Control:

No control over staff numbers (4 OP), no one in Directorate can actually dictate or have a say in staffing levels (3Pd), our whole lives are hinging around two things, WTEs and bed capacity (1b).

Don't know level of vacancies and costs (1b)

Capability:

Consultant Management Training was a management course of one week's duration at the end. No preparation here... 3 to 4 sessions since (2c) (but) no formal education or training in management (2a),

We didn't get much training (2b), No training, we hold our own meetings and identify our training needs. (2c)

Performance Management: Roles & Resources

Constraints:

ISIT National: Supposed to be a strategy; need to shake up; don't appear to understand needs at hospital level (1c).

GUH ISIT Capacity: Had to build our own independent system (1c); willing to engage and improve hospital's performance but not sure if they understand the information required (1h); ICT role in Radiotherapy and Lab, trying to establish role in M&S (1h);

Finance & HR are really quite poor, working with CDs we rely on people to give information (1a), we have the finance tools (1c).

HIPE provides activity data (1b) but no seasonal changes, can't tell trends (3 Ob, big deficit in coding, backlog 23k cases (1h), need more information for different groups (2c), Paeds info is limited (2b).

Medical Records: No EPR (1a); A problem in the management of medical records, a task force assigned in weak areas (1k), started e discharge summary.

STARS WEB: In use (3 Oc), incident report and dissemination to all Depts (2c)

EuroKing: In use and Q Pulse initiated (3 Oc).

EuroCat: Congenital Abnormalities Centre (3 Pd)

GUH CIS Status: Poor in the past and still restricted in what we can do (1c), needs improvement (1k), very good in Radiotherapy and ICU, but needs evaluation (1d).
W&C CIS Status: OG very good, works with IT & dramatically improved in their understanding (1c),
Good in W&C (2b), OG use CIS (3Oa,c), unique in producing information regularly, (but) not a part of the reporting structure (1c).
Not in Paeds (1b) nominal (1a,h), manual (1c, 3Pd), very low in technology but have some internal measures (1g), don't have IT so we cant look up the (necessary) type of stats (3Pa)

Performance Management: Standards and data.

Clinical: CIS is crucial! My clinical data was most helpful to me in analysing the issues and trying to ascertain where the priorities lay, a lay person could be led up the garden path (2a).

Perinatal mortality reviewed monthly (3 Oa). Rudimentary! (3 Oa)

I don't do anything (data), I have a diagnostic index for my outpatients (3Pd).

GUH: We have some (PIs) but they are difficult to implement and I look at my own level of performance re WTEs (1a). We plan to improve and will participate in the national project (1h) Will try to agree some KPIs in some specialties eg W&C (1a). PIs (CD) in Service Plan (1g).

Targets devolved to each specialty (1a). A Dashboard is being evolved, efficiency ratios, benchmark (ATHs) and NHO waiting times (1h). HIQA standards are putting pressure! (1g).

W&C: set themselves action plans, measures, outputs and outcomes (1d). Don't know, standards are my own personal experience, 30years in total control of my patients until that changed (3Pd). W&C have a reasonable handle on activity and performance (1k)

Limitations: Performance management is underdeveloped here (1a), we don't really measure performance for results (2c), no self regulation, we basically monitor ourselves (1k), we have to have self regulation; more investment is required in control systems (1a).

Quality Management

Quality Model: No specific model (1a, 2b, 3 Oa, 3Pa), a combination of different ways of managing quality (3Pa); a bit traditional (ISO, Accreditation, Fora, Feedback) (2a), Quality talk tends to be about improving service and not quality (3 Oa).

Quality Strategy: Quality in the mission statement and partnership process (1j); excellent risk management strategy, CRM based on it (2e). Quality is in everything. We have to set standards in policy and procedure (1k). Quality Plan sets targets.....a slow process (1b).

Quality Agenda: Very much on agenda (hospital) (1g).

Not on formal CD agenda deliberately (2b), Not seen as a recurring item on agenda (3c), the agenda of CD is to an extent to develop guidelines and procedures (3Pa).

Quality Structure: The CQI Committee gets issues from the CD (1c) and nominations to the committee and 3 sub-committees (1j), looks at multidisciplinary policies and procedures (1b). The Chair links to the Medical Board. It is very much clinician-led, protocols and guidelines are very high on agenda. 2 years ago it would not have happened (1j), it has strength but it can only pick small areas at a time (1k).

QI W&C: QI Team in OG only, meets monthly (3 Oc), QI is the responsibility of BM (3 Oc), Clin Dir has a certain responsibility for managing quality (3Pa).

Labour Ward Forum: All disciplines talk issues eg risk and recurring topics (3 Oa)

CRM Committee: W&C rep on CRM Committee (2e); very active RM Group with Senior Nurse. They are good to work on policy and procedures. They produce the critical incident report (1g). RM meets GM weekly and discusses issues (1j), monthly quality meeting (2b).

CRM W&C: CD has input to CR & Patient Safety (3Pa). Dir. provides overview of clinical risks and addresses them (3Pa). Needs a dedicated person like Clin. Dir. Because of lack of ownership it comes back to us for follow up (2e). Risk Advisor reports incidents and relays them back to staff meetings (3Pb). I don't get reports; Sr looks after that (3Pd).

CRM Reports reviewed weekly at CD meetings (2b), Weekly review of CR forms in Labour Ward (3 Oa, Pa), very serious cases reviewed immediately and feed into Risk Advisors (3 Oa).

Clinical Audit:

Reports presented at monthly meetings (3C). C Section Audits monthly with national and international comparison (3a), Perinatal Mortality Review monthly (3a).

CA Performance: Internal audits aspire to quality, selected on a need to know basis eg Breast Screening (1g). Not enough CA Projects. W&C are one of the better ones but not enough from Paeds (poor relation!) (1j), conduct random audits (1b). CA is not prominent, mainly medical. Nursing audit is in its infancy (3 Ob), purely medical audit and not multidisciplinary (1k), don't audit as such (3Pd). Ireland is very poor in auditing outcomes (3Pa).

ISO:

Started in OG, lent itself to quality. Not my first choice (1a). Use ISO standards and compliance (3 Oa),.

Kept ISO Cert since 1996 (3 Oc), OG far ahead in programme, advanced ISO, a very good tool for managing quality (2b), OG more advanced than Paeds (need some buy-in) (1g). Accreditation Group will decide re Paeds/ISO (3 Oc). Should roll-out to Paeds (3Pb). Don't use ISO (3Pa)

Good policy and procedures, audit gives more coherence (2c); comprehensive policy and procedure statements (3 Oa). Documented process, the system of updating is very good, a lot of information is managed very well and is available. Quite a quality system the way it is managed (3 Oa).

Internal quality audit use ISO standards for compliance and correction (3 Pc). ISO facilitated the transfer to Accreditation (1g). We will go with Q Pulse to improve communications (3 Oc).

Accreditation:

Committed to Accreditation process. It is a catalyst for very positive improvement (1a). Very pre-occupied with Accreditation Audit (2a).

GM & DN first trained as assessors. They embraced it from its inception. It is a unifying experience that promoted multi-disciplinary working. People met people they never met before (1b). Very positive around team working. It has put quality on everyone's agenda in the Hospital involving patients and more. The journey of getting there is CQI (1a). Increased development and training and multi-disciplinary working (1d). The process has been hugely beneficial (1k). An overwhelming process. We cannot achieve some of the things. It highlighted our good points and deficiencies (3Pa). It transmits quality. A self-assessment process flagging up deficits in policy and guidelines (1j).

Negative? No impact on practice (3Pd). Don't know enough to buy into it. I am not hugely impressed. The site visit did not engage clinicians or women but it is good to be aiming for something (3 Oa).

Quality: Overview

GUH: Q is very good (4P). Q is very good. Nurse standards are extremely high (3Pd). The Hospital Steering Group has had a huge impact since set up (3Pd).

Negative? Not sure if people see quality as part of everyday work (1k). Quality is not embedded in day to day business (1h)

W&C: Made inroads to quality, CD is doing well (3Pa) QI team in OG only (3 Oa). OG came a long way in Quality and Risk; better than most (2e). Contributed to quality focus; put patient at centre, always looking at something new to improve care (1b). 9/10 for listening to patients in OG (3 Oc).

Very effective, satisfaction rating 98% from comment cards (on patient discharge) (2b).

Benchmark: W&C Annual Reportall put up front publicly eg high risk incidents, perinatal death (no external comparison) (2a). No formal benchmark (2c). Paeds fed into Vermont/Oxford database (2b) a quality control database on quality and outcomes. We can see our performance against the rest of the world (3Pa).

Feedback: From Patient Focus Groups (3c); do a lot of Focus Groups with parents (2c)

Complaints: DN responsible (1b).

What has to Change?

Budget and Staff Numbers Control:

We would like full involvement in the budget. Give us autonomy and WTEs. Be more supportive (1g). Devolve the budget, reward people for change. All the CDs say that if they implement change in their own areas unless they see a reward, it is very hard to convince people of the benefit...as the following year you are penalised as the budget is based on last years performance, so you are penalised! (1k). Have our own budget and responsibility for spend (2b).

Need budget devolution; otherwise it is a pseudo-directorate (2c). Need more devolved budget if they want us to manage our affairs (3 Oe). Need our own budget, staff, recruitment and HR (4P).

Need adequate staffing levels, not crisis management, to perform my role as a manager (3Pc)

Be more supportive; give power and information (1g). Need more information for decision making, more autonomy (2c). These things need to be in our hands (3 Oc). Need more flexibility. A lot of flexibility is gone and there are a lot of inefficiencies (1h). Lift the embargo! (1b). Staff levels too low. (4P)

Management:

Get all managers trained; the only person who knows what's happening on the general side is C. There is a different culture there (3 Oc). Need better communications from the Director down; not often communicated with... (4P). Hope to have more input (4P).

Structure:

Need a national formalisation of the role of CD and it needs to be given substance (2c). Combine the 2 Units and gain efficiencies in the system (3Pd)

Improve the buildings (too distant from Hospital), more beds required. Hope we to see more improvements with CD (4P)

Clinical Governance:

We will move to some degree of TQM next, CQI would be better (1a).

Get involved! (2c). Hopefully the CD will push Clinical Leadership (3 Oc). Clinicians have to buy into Q data for planning (1h). Require more active reporting of incidents, clinical risk and unreported incidents are a worry. We want to see the Risk Register up and running and prioritise risk in the organisation (2e).